Long-Term Care Insurance

The Company You Keep®

Outline of Coverage, Application, and Forms For the State of **California**

(This booklet contains the forms necessary to apply for New York Life's Long-Term Care Insurance)

Table of Contents

Disclaimer: This Application and Outline of Coverage are for use with policy form series ILTC-5000 and INH-5000. This summary contains a brief description of New York Life's Individual Long-Term Care Insurance Policies and is not intended to present complete details. The actual terms of coverage will be subject to the provisions contained in the policy issued to you by New York Life Insurance Company.

13690 (CA) (0917)

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NEW YORK LIFE INSURANCE COMPANY
51 Madison Avenue, New York, NY 10010

Important Notice to California Applicants

The State of California requires long-term care insurance insurers to notify you of your right to obtain a specimen copy of each individual policy New York Life currently sells in California. You may view the specimen policies at our website www.newyorklife.com, under the Long-Term Care Insurance section. If you would like a paper copy of a specimen policy, contact our Call Center at 1-800-224-4582 or send your written request to us. We will provide the specimen policy to you within 15 calendar days of your request.

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Important Privacy Choices for Consumers

You have the right to control whether we share some of your personal information.
Please read the following information carefully before you make your choices below.

Your Rights

You have the following rights to restrict the sharing of personal and financial information with our affiliates (companies we own or control) and outside companies that we do business with. Nothing in this form prohibits the sharing of information necessary for us to follow the law, as permitted by law, or to give you the best service on your accounts with us. This includes sending you information about some other products or services.

Your Choices

Restrict information sharing with companies we own or control (Affiliates): Unless you say "No," we may share personal and financial information about you with our affiliated companies.

❑ NO, please do not share personal and financial information with your affiliated companies.

Restrict information sharing with other companies we do business with to provide financial products and services: Unless you say "No," we may share personal and financial information about you with outside companies we contract with to provide financial products and services to you.

❑ NO, please do not share personal and financial information with outside companies you contract with to provide financial products and services.

Time Sensitive Reply

You may make your privacy choice(s) at any time. Your choice(s) marked here will remain unless you state otherwise. However, if we do not hear from you, we may share some of your information with affiliated companies and other companies with whom we have contracts to provide products and services.

Name: _____

Account or Policy Number(s): _____

Signature: _____

To exercise your choices do one of the following:

(1) Fill out, sign and send back to us using the envelope provided (you may want to make a copy for your records):
(2) Fax this form to us toll-free at (952) 833-5410; or
(3) Call this toll-free number (800) 695-4331.

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(3) Call this toll-free number (800) 695-4331.

The Company You Keep®

Privacy Policy

Our information practices

Our policies and procedures protect the privacy of current and former customers.

Types of Information We Collect

In the normal course of business we collect:

- Information requested on applications and other forms (including name, address, income and household information);
- Data about your transactions (such as the products you purchase and your account status);
- Information from outside sources such as public records;
- Information gathered from our websites, such as through online forms, site visit data and information collection devices ("cookies");
- Information collected from consumer credit reporting agencies; and
- Health information collected with your permission when you apply for products, such as life insurance or long-term care insurance.

Safeguarding your information

New York Life maintains physical, electronic and procedural safeguards that meet state and federal regulations. Access to customer information is limited to people who need the information to perform their job responsibilities.

Please note that this notice applies to residents of California.

How We Use Your Information

New York Life may share the information we collect about you as allowed by law, including for normal business administration and related business activities.

The information may be shared:

- Within the New York Life Family of Companies; and
- With non-affiliates, such as banks, third parties that perform research and marketing functions for us or service providers that help us process transactions or service your accounts. Our service providers may include New York Life agents, billing, printing and mail service companies. If you are an investment advisory services customer, we may share your information with third parties who help us service your investment and financial planning needs.

We may disclose the information we collect about you when required or permitted by law, such as to:

- Respond to a subpoena;
- Prevent fraud or other crimes;
- Comply with legal requirements; or
- Respond to a government inquiry.

IMPORTANT PRIVACY CHOICES

New York Life respects your privacy choices. You have the option to tell us not to share your information as follows:

- Within the New York Life Family of Companies to let you know about our products and services. The information we share may include household and financial data.
- With non-affiliated companies with which we have joint agreements, such as banks, credit card issuers and online services, to offer you their products and services. The information we share may include name, address and information about your transactions with us.

Please review the enclosed notice entitled "Important Privacy Choices for Consumers."

If you do not want us to share your information in one or both of the ways described above, just call (800) 695-4331 and let us know.

Retain

The choice you make will apply to all the products you purchased from the New York Life Family of Companies. If one joint owner tells us not to share information, that choice will also apply to the other owner(s). **If you have already told us of your choices, there's no need to call again.**

We will follow the privacy law in your state if that law has different requirements than the policy described in this notice.

Informing Customers About Privacy

This privacy policy is in effect as of July 1, 2015. You will receive our privacy policy at least once a year, as long as you are a policyholder or client. You can receive additional copies of our privacy policy by writing to:

New York Life
P.O. Box 6916
Cleveland, OH 44101

You can also call us toll free at (800) 695-4331.

Important Information About Procedures for Opening a New Account

Federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account.

What this means for you: When you open an account, we will ask for your name, address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

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*The New York Life Family of Companies (also referred to as "New York Life Family," "we," "our" or "us") currently includes the following insurance and .financial services affiliates and funds:

New York Life Insurance Company
New York Life Insurance and Annuity Corporation
New York Life Investment Management LLC
New York Life Enterprises LLC
Ausbil Investment Management Limited
Candriam Belgium SA
Candriam France S.A.S.
Candriam Luxembourg S.C.A.
Cornerstone Capital Management LLC
Cornerstone Capital Management Holdings LLC
Eagle Strategies LLC
GoldPoint Partners LLC
IndexIQ, Inc,
Institutional Capital LLC
MacKay Shields LLC
Madison Capital Funding LLC
MCF Capital Management LLC
MainStay Defined Term Municipal Opportunities Fund
The MainStay Funds
MainStay Funds Trust
MainStay VP Funds Trust
Private Advisors Alternative Strategies Fund
Private Advisors Alternative Strategies Master Fund
Private Advisors, LLC
New York Life Trust Company
NYLIFE Distributors LLC
NYLIFE Insurance Company of Arizona
NYLIFE Securities LLC
NYLIM Service Company LLC
NYLINK Insurance Agency Incorporated
NYL Investors LLC

OUTLINE OF COVERAGE
Long-Term Care or Nursing Facility and Residential Care Facility Only Insurance

NEW YORK LIFE INSURANCE COMPANY
51 Madison Avenue, New York, NY 10010

To be retained by the APPLICANT(S)

❑ Policy Form No. ILTC-5000 (CA) (0112)	Individual Comprehensive Long-Term Care Insurance Policy
❑ Policy Form No. INH-5000 (CA) (0112)	Individual Nursing Facility and Residential Care Facility Only Insurance Policy

FEDERAL TAX-QUALIFIED COVERAGE: THIS CONTRACT FOR LONG-TERM CARE INSURANCE IS INTENDED TO BE A FEDERALLY QUALIFIED LONG-TERM CARE INSURANCE CONTRACT AND MAY QUALIFY YOU FOR FEDERAL AND STATE TAX BENEFITS.

THIS POLICY IS AN APPROVED LONG-TERM CARE INSURANCE POLICY UNDER CALIFORNIA LAW AND REGULATIONS. HOWEVER, THE BENEFITS PAYABLE BY THIS POLICY WILL NOT QUALIFY FOR MEDI-CAL ASSET PROTECTION UNDER THE CALIFORNIA PARTNERSHIP FOR LONG-TERM CARE.

FOR INFORMATION ABOUT POLICIES AND CERTIFICATES QUALIFYING UNDER THE CALIFORNIA PARTNERSHP FOR LONG-TERM CARE, CALL THE HEALTH INSURANCE COUNSELING AND ADVOCACY PROGRAM AT THE TOLL-FREE NUMBER, 1-800-434-0222.

Caution: The issuance of this Long-Term Care Insurance Policy is based upon Your responses to questions on Your Application. A copy of Your Application is attached to Your Policy when issued. If Your answers are incorrect or untrue, New York Life Insurance Company has the right to deny benefits or rescind Your Policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of Your answers are incorrect, contact New York Life, PO Box 64670, St. Paul, Minnesota 55164-0670.

Notice to Buyer: The Policy may not cover all of the costs associated with the long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.

1. The Policy is an individual policy of long-term care insurance or nursing facility and residential care facility only insurance that is issued in California, the state of solicitation of the Policy and the state where the application was signed.

2. **PURPOSE OF OUTLINE OF COVERAGE.** This Outline of Coverage provides a very brief description of the important features of the Policy. You should compare this Outline of Coverage to outlines of coverage for other policies available to You. This is not an insurance contract, but only a summary of coverage. Only the Policy contains governing contractual provisions. This means that the Policy sets forth in detail the rights and obligations of both You and New York Life Insurance Company (herein referred to as New York Life, We, Our, or Us). Therefore, if You purchase this coverage, or any other coverage, it is important that You **READ YOUR POLICY CAREFULLY!**

3. **TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND PREMIUM REFUNDED.**

   a. **30-Day Free Look.** You have 30 days from the day You receive the Policy to examine it. If You are not satisfied with the Policy for any reason within 30 days of receipt, You may return it to New York Life, PO Box 64670, St. Paul, Minnesota 55164-0670 or to Your producer. Upon Our receipt of any Policy You have returned within the initial 30 days, We will return any premium paid and coverage will be void from the start.

   b. **Premium Refund for Voluntary Policy Surrender or Upon Your Death.** If Your Policy terminates for any reason, We will refund to You any premiums that You have paid past the date of termination. Any payments We make after We receive notification of Your death will be made to Your estate.

Retain

4. **THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.** If You are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from Us or Your producer. Neither New York Life nor its producers represent Medicare, the federal government or any state government.

5. **LONG-TERM CARE COVERAGE.** Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a Nursing Facility, in the community or in the home.

   The Policy provides coverage in the form of an expense reimbursed benefit for covered qualified long-term care expenses, subject to benefit eligibility, policy limitations, elimination periods, and daily and lifetime policy maximums.

6. **NURSING FACILITY BENEFITS PROVIDED BY THE POLICY.**

   a. **Elimination Period and Policy Maximums.**

      (1) **Elimination Period.** The Policy contains an Elimination Period, which is like a deductible. The Elimination Period is the initial number of days that You must receive care or services before benefit payments will begin. The Policy will not pay for care or services received or provided during the Elimination Period. Only days on which You receive care or services covered either under the Policy or by Medicare count toward meeting the Elimination Period. Some Benefits are not subject to the Elimination Period and amounts paid for those Benefits will not count toward satisfying the Elimination Period. The Benefit descriptions below indicate if that Benefit is subject to the Elimination Period.

      Once You have met all the conditions of the Eligibility for Payment of Benefits provision and have satisfied the Elimination Period, the Policy will begin paying benefits for covered care or services. The days counted toward Your Elimination Period do not have to be consecutive, but only service days will be counted, subject to the provisions of the Policy.

      The Policy has an Elimination Period of 20, 90, 180 or 365 days. You select the Elimination Period You want for Your Policy at the time of application.

      (2) **Policy Maximums.** The Policy contains maximum benefits that may be paid for certain Benefits.

         (a) **Policy Lifetime Maximum Benefit.** The Policy Lifetime Maximum Benefit is the maximum dollar amount that will be payable for Benefits under the Policy. The Policy Lifetime Maximum Benefit is shown in the Schedule of Benefits of Your Policy. No further benefits are payable once the total benefits paid equals the Policy Lifetime Maximum Benefit.

         The Policy Lifetime Maximum Benefit is determined by multiplying the Nursing Facility Maximum Daily Benefit by a multiplier. The multiplier is the number of days in the benefit period selected by You at the time of application. The benefit periods and multipliers are: 2 years (730 days), 3 years (1095 days), 4 years (1460 days), 5 years (1825 days), 7 years (2,555 days), 10 years (3,650 days) and Unlimited (lifetime) (no multiplier).

For example, if You select $100 per day as Your Nursing Facility Maximum Daily Benefit and You select a 2-year benefit period, Your Policy Lifetime Maximum Benefit would be:

$100 X 730 (2 years times 365 days) = $73,000.00

(b) **Nursing Facility Maximum Daily Benefit.** The Nursing Facility Maximum Daily Benefit is the maximum dollar amount payable for any one day of care in a Nursing Facility or a Residential Care Facility. The Nursing Facility Maximum Daily Benefit is selected by You at the time of application and is described below.

(c) **Home and Community-Based Care Maximum Daily Benefit.** The Home and Community-Based Care Maximum Daily Benefit is the maximum dollar amount that is payable on any one day, except as provided for the Advantages of Using the Care Coordinator provision described below.

The Home and Community-Based Care Maximum Daily Benefit is a percentage of the Nursing Facility Maximum Daily Benefit and that percentage is selected by You at the time of application. The allowable percentages are:

- 0% (for a Policy with no Home and Community-Based Care Benefits – Nursing Facility and Residential Care Facility Only Insurance; or
- 50% to 100% in 10% increments. **The minimum You must have for Home and Community-Based Care is $50 per day.**

(d) Other maximum benefits or limits to benefit payments are described in the Benefit provisions to which they apply. Benefit provisions are described below and are described in more detail in the Policy. The Limitations and Exclusions of the Policy are described both below and in the Policy. In the case of any conflict between descriptions in this Outline of Coverage and the Policy, the Policy language will govern.

b. **Institutional Benefits.**

(1) **Nursing Facility Care or Residential Care Facility Benefit.** We will pay the Eligible Charges for each day that You are confined in a Nursing Facility or a Residential Care Facility for up to the Nursing Facility Maximum Daily Benefit selected, provided that Your stay must begin while Your coverage under the Policy is in force.

(a) The Eligible Charges of a Nursing Facility or a Residential Care Facility include only the daily charge to inpatients for room and board plus ancillary supplies and services.

(b) The Eligible Charges while You are confined in a Residential Care Facility may include other charges covered by the Policy up to the Nursing Facility Maximum Daily Benefit.

(c) The Elimination Period applies to this Benefit, and amounts We pay will count against the Policy Lifetime Maximum Benefit.

Nursing Facility Maximum Daily Benefit: $100 to $400 based on Your selection.

Reminder: The Daily Benefit for Home and Community-Based Care is $50 per day.

(2) **Bed Hold Reservation Benefit.** After You have been approved for and are receiving benefits for Nursing Facility or Residential Care Facility benefits, We will pay a benefit for each day (up to 30 days per calendar year) to assure a place will be available for You when You return from a temporary absence for any reason.

(3) **Extended Coverage Benefit.** If You are confined in a Nursing Facility or a Residential Care Facility and You are receiving benefits while the Policy is in force, and You continue to be confined without interruption after the Policy lapses or terminates, We will extend benefits by continuing to pay benefits for such confinement while You remain so confined, up to the Policy Lifetime Maximum Benefit.

c. **Non-Institutional Benefits.**

(1) **Home and Community-Based Care.** These Benefits are available when You receive care or services in Your home or residence, in the community or when You are confined in a Residential Care Facility. For each day You receive Home and Community-Based Care, We will pay the Eligible Charges for the Home and Community-Based Care You receive on that day, up to the Home and Community-Based Care Maximum Daily Benefit. Home and Community-Based Care includes Home Health Care, Adult Day Care, Personal Care and Homemaker Services. Such services may be provided by skilled or unskilled workers, **but will not be paid when services are provided by a Family Member who lives in Your home or residence.** You may not receive Home and Community-Based Care Benefits while you are confined in a Nursing Facility. **(These benefits are not available in the Nursing Facility and Residential Care Facility Only Insurance Policy.)**

(a) **Home Health Care.** Benefits for Home Health Care are only payable if provided by a person who:

(i) Is employed by a Home Health Agency; or

(ii) Is properly licensed to provide such services, if licensure is required by the jurisdiction where the care or services are performed.

(b) **Adult Day Care.** Benefits for Adult Day Care are payable for Eligible Charges for care and services provided by an Adult Day Care Center.

(c) **Homemaker Services.** Benefits for Homemaker Services are payable when such services are performed by a person who:

(i) Is employed by a Home Health Agency; or

(ii) Is properly licensed to provide such services if licensure is required by the jurisdiction where the care or services are performed.

(d) **Personal Care.** Benefits for *Personal Care* are only payable when such services are performed by a person who:

(i) Is employed by a Home Health Agency; or

(ii) Is properly licensed to provide such services if licensure is required by the jurisdiction where the care or services are performed.

(e) **Other Considerations.** You cannot receive benefits under the Home and Community-Based Care Benefit for any day on which We are also paying Nursing Facility Benefits or other benefits because You are confined in a Nursing Facility.

The Eligible Charges while You are confined in a Residential Care Facility may include other charges covered by the Policy up to the Nursing Facility Maximum Daily Benefit.

The Elimination Period applies to this Benefit. Any amounts We pay under this Benefit will be counted against the Policy Lifetime Maximum Benefit.

d. **Other Benefits Included in The Policy**

(1) **Durable Medical Equipment Benefit.** We will pay the charges You incur to purchase or rent Durable Medical Equipment, up to the Durable Medical Equipment Lifetime Maximum Benefit, provided that the Durable Medical Equipment must be prescribed in Your Plan of Care; and

(a) Be first purchased or rented after the Policy Effective Date.

(b) The Durable Medical Equipment must enable You to perform any of the Activities of Daily Living and allow You to remain in Your home for an expected period of at least 90 days after the purchase or rental; and

(c) The Durable Medical Equipment must not materially increase the value of Your home or residence.

The Elimination Period does not apply to the Durable Medical Equipment Benefit. Any benefits We pay under this Benefit will not be considered daily benefits. **(This benefit is <u>not</u> available in the Nursing Facility and Residential Care Facility Only Insurance Policy.)**

(2) **Care Coordinator Benefit.** We will pay the Care Coordinator's charges to prescribe a Plan of Care for You, if You request the Care Coordinator Benefit. We will pay the charges for the Care Coordinator, except if You elect to provide Us with a Plan of Care from a Licensed Health Care Practitioner instead of the Care Coordinator, We will evaluate Your claim and pay benefits in accordance with the Policy's provisions.

(a) While You are following the Plan of Care prescribed for You by the Care Coordinator, We will also pay:

(i) The charges of the Care Coordinator to determine if You remain a Chronically Ill Individual and to prescribe a current Plan of Care for You at least annually; and

(ii) The Care Coordinator's charges to coordinate the services You receive under Your Plan of Care.

You do not have to meet the Elimination Period to use the Care Coordinator, and the amounts We pay the Care Coordinator do not count against Your Policy Lifetime Maximum Benefit. You must, however, satisfy the applicable Elimination Period before We will pay benefits for any care or services the Care Coordinator coordinates, and the benefits We pay will count against the Policy Lifetime Maximum Benefit as provided in each Benefit.

(b) **Advantages of Using the Care Coordinator.** While You are following the Plan of Care prescribed by the Care Coordinator, We will also enhance Your Home and Community-Based Care Benefit as follows: **(This benefit is <u>not</u> available in the Nursing Facility and Residential Care Facility Only Insurance Policy.)**

(i) We will reduce the Elimination Period that must be satisfied before the Home and Community-Based Care benefits are payable to 20 days of service. The full Elimination Period must be satisfied before benefits other than Home and Community-Based Care are payable.

(ii) We will determine Your Home and Community-Based Care benefits on a monthly, rather than a daily basis. This means that We will pay the Eligible Charges You incur for Home and Community-Based Care benefits in any calendar month, up to 31 times the Home and Community Based Care Maximum Daily Benefit shown on the Schedule of Benefits of the Policy.

(iii) We will pay a benefit for each day on which You receive at least 4 hours of Informal Care **(which will not be paid when provided by a Family Member who lives in Your home or residence)** and on which no other covered services are provided. We will pay:

1. An Informal Care daily indemnity benefit of **50% of the Home and Community-Based Care Maximum Benefit**; up to
2. A lifetime maximum of 365 days while Your coverage is in force.

(3) **Informal Caregiver Training Benefit.** We will pay the cost of training a person to provide You with Informal Care in Your residence, up to a lifetime maximum of 5 times the Nursing Facility Maximum Daily Benefit, provided that:

(a) The training must be prescribed in Your Plan of Care;

(b) The training cannot be received while You are confined in a hospital, Nursing Facility or a Residential Care Facility, unless it is expected that You will return home where the person that is receiving the training can care for You; and

(c) We will not pay any benefits to train an individual who will be providing care other than Informal Care for You.

You do not have to meet the Elimination Period to use this Benefit. The benefits We pay under this Benefit are not considered a daily benefit, and days on which any person is being trained under this Benefit do not count toward satisfying the Elimination Period.

(4) **Respite Care Benefit.** We will pay a benefit for each day You receive care, up to a maximum of 21 days per calendar year, to allow those caring for You at home to get temporary relief (for example, for a holiday, vacation, or emergency).

(a) For each day that You receive care and are confined in a Nursing Facility or a Residential Care Facility, We will pay the Eligible Charges of the Nursing Facility or Residential Care Facility, up to the Nursing Facility Maximum Daily Benefit.

(b) For each day that You receive Home and Community-Based Care, We will pay the Eligible Charges for Home and Community-Based Care, up to the Home and Community-Based Care Maximum Daily Benefit.

You do not have to meet the Elimination Period before We will pay benefits under this Benefit, and the days for which We pay benefits under this Benefit do not count toward satisfying the Elimination Period.

(5) **Hospice Care Benefit.** If You become Terminally Ill, for each day You receive care provided by a Hospice, We will pay:

(a) The Eligible Charges of the Hospice; up to

(b) The Nursing Facility Maximum Daily Benefit amount.

(c) Provided that You meet all of the requirements of the Eligibility For The Payment Of Benefits provision of the Policy.

The Elimination Period does not apply to this Benefit, and the days on which We pay benefits under this Benefit do not count toward satisfying the Elimination Period.

(6) **World Wide Coverage Benefit.** If You become eligible for benefits while outside the United States or its territories, the Policy will pay its benefits in accordance with its terms for Eligible Charges You incur for covered services received outside the United States or its territories, up to a lifetime maximum of 100 times the Nursing Facility Maximum Daily Benefit.

(7) **Request for Non Listed Benefits.** Once You have met all of the conditions of the Eligibility For The Payment of Benefits provision, You may request a Request for Non Listed Benefits. If We agree, We will pay benefits in accordance with the Request for Non Listed Benefits provision of the policy. The following additional terms apply under this Benefit:

(a) Except as We expressly agree in the Request for Non Listed Benefits, Your rights and Ours will be governed by all of the Policy terms.

(b) All of the benefits We agree to pay under the Request for Non Listed Benefits must be for Qualified Long-Term Care Services as defined in Internal Revenue Code Section 7702B(c).

(c) We may agree with You only for a set period of time (for example, one year). At the end of that period of time, the Request for Non Listed Benefits will end unless We agree with You to renew it. You may terminate a Request for Non Listed Benefits at any time, by giving Us at least 15 days advance written notice of the termination.

(d) After a Request for Non Listed Benefits terminates, We will resume paying benefits for Eligible Charges You incur in accordance with all of the terms of the Policy.

(e) Requests for Non Listed Benefits are necessarily unique to each insured, and We reserve the right to decline to agree to any such request, or to any proposed term of a Request for Non Listed Benefits, but We will consider all requests for a Request for Non Listed Benefits on a non-discriminatory basis.

(8) **Waiver of Premium Benefit.** After You have satisfied the Elimination Period and are receiving benefits under the Policy, the premium payments which become due will be waived. You do not have to pay any premium payments until You are no longer receiving benefits. If Your premium payment mode is other than monthly, Your premium payment mode will be changed to monthly. If Your premium payment mode is other than monthly when You begin to actually receive benefits, any premium which You have already paid for any coverage during the period for which premiums are waived will be returned to You.

(9) **Contingent Nonforfeiture Benefit.** The Contingent Nonforfeiture Benefit will be triggered if you do not have the Optional Nonforfeiture Benefit Rider in force and if:

(a) We increase the premium rates to a level which results in a substantial cumulative increase in the premiums for the policy; and

(b) This Policy lapses within 120 days of the due date of the premium so increased.

The purchase of additional coverage will not be considered a premium rate increase, nor will a reduction in benefits be considered a premium change.

On or before the effective date of a substantial premium increase that could trigger the Contingent Nonforfeiture Benefit, we will:

(a) Offer to reduce the benefits of the Policy so that the current premium payments are not increased;

(b) Offer to convert the coverage to a paid-up status with a shortened benefit period based on the contingent nonforfeiture benefit amount. This option may be elected at any time during the 120-day period; and

(c) Notify You that a lapse at any time during the 120-day period will be deemed to be the election of the offer to convert to paid-up coverage.

If the Contingent Nonforfeiture Benefit becomes effective, then benefits will be payable under the Policy any time You qualify for benefits during the remainder of Your life; subject to all the terms and conditions of the Policy; and will be based on all the Maximum Daily Benefit(s) and Lifetime Maximum Benefit(s) in effect at the time of lapse and not increased after lapse.

The contingent nonforfeiture benefit amount will be the greater of 100 percent of the sum of all premiums paid, including the premiums paid prior to any changes in benefits or thirty (30) times the Nursing Facility Maximum Daily Benefit at the time of lapse.

The contingent nonforfeiture benefit amount will not exceed the remaining Policy Lifetime Maximum Benefit at the time the Policy lapses and the Contingent Nonforfeiture Benefit becomes effective.

(10) **Restoration Benefit.** For each complete year following Your recovery from a loss for which benefits have been paid under the Policy, We will add to Your Policy Lifetime Maximum Benefit 100 times the Nursing Facility Maximum Daily Benefit. The Policy Lifetime Maximum Benefit will never be greater than it would have been if no benefits had been payable under the Policy. Only Your Policy Lifetime Maximum Benefit is affected by this Benefit. Any other Limitations and Exclusions on individual benefit payments contained in the Policy remain unaffected by this provision.

(11) **Optional Benefits.** In addition to the Optional Riders described in the Relationship of Cost of Care and Benefits provision below, the following are optional benefits that You may select and which will be provided at an additional premium cost:

(a) **Shared Care Rider.** This optional rider can be selected when both spouses have identical long-term care insurance policies in force with New York Life Insurance Company with the same Policy Effective Dates. If both policies are in force when one of the insured spouse's Policy Lifetime Maximum Benefit is reached, additional benefits will be payable under that insured's policy up to the Shared Care Maximum Benefit. The Shared Care Maximum Benefit of one spouse will be reduced by any benefits previously paid for the other spouse under the Shared Care Rider attached to that person's Policy. This optional rider has additional requirements to keep the Rider in force that are described in the termination section of the Rider.

Divorce or dissolution of marriage will not automatically terminate this Rider. Divorce or dissolution of marriage will not cause the premiums of this rider to increase.

(b) **Couples Additional Benefit Rider.** This optional rider can be selected when both spouses have identical long-term care insurance policies in force with New York Life Insurance Company with the same Policy Effective Dates. This optional rider has additional requirements to keep the rider in force that are described in the termination section of the Rider. Each of the following additional benefits will be payable while the Rider remains in force with respect to that additional benefit:

(i) **Spousal Premium Waiver Benefit.** This Benefit will waive the premiums for the Policy and any attached Riders for any period of time for which Your spouse's premiums are waived due to the Waiver of Premium provision of the spouse's Policy. The waiver does not include unscheduled increases in coverage amounts or other changes to the Policy after Spousal Premium Waiver Benefits become payable.

(ii) **Spousal Elimination Period Benefit.** This Benefit will allow any day either You or Your spouse is eligible for benefits to count toward Your Elimination Period. Any day You and Your spouse are both eligible for benefits will count as two days toward Your Elimination Period.

(iii) **Survivorship Benefit.** This Benefit provides that if Your spouse dies after Your spouse's Policy has remained in effect for at least 10 years while this Benefit remains in force, then Your Policy, including any attached Riders, will become paid-up and no further premium payments will be required. This Benefit will terminate on the earliest of the following to occur:

1. You become eligible for benefits under the Policy within the first 10 years it is in force;
2. Your spouse becomes eligible for benefits under Your Spouse's Policy within the first 10 years it is in force; or
3. The Couples Additional Benefit Rider terminates.

Divorce or dissolution of marriage will not automatically terminate this Rider. Divorce or dissolution of marriage will not cause the premiums of this rider to increase.

(c) **Return of Premium Upon Death Benefit Rider.** This Benefit provides that if You die while this Rider and Your Policy are in force a Return of Premium Upon Death Benefit will be paid in one lump sum to Your estate. The amount payable will be calculated as follows:

(i) The sum of all premiums paid for Your Policy (with no accumulation for interest and excluding any premiums waived);

(ii) Less the amount of any benefits paid or payable under Your Policy.

Coverage under this Rider will terminate when the first of the following occurs:

(i) Your coverage under the Policy ends;

(ii) The first day of the following month after You notify Us in writing that You wish to terminate Your coverage under this Rider;

(iii) The Premium Due Date of any premium for this Rider not paid by the end of the Grace Period; or

(iv) The first day You become eligible for an Optional Nonforfeiture Benefit or a Contingent Nonforfeiture Benefit.

No Return of Premium Upon Death Benefit will be paid if You die after this Rider terminates.

NOTE: The payment of the Return of Premium Upon Death Benefit may have Federal Income Tax consequences. New York Life Insurance Company does not give legal or tax advice. However, We do recommend that You consult a qualified tax professional or attorney to determine any tax implications.

(d) **Optional Nonforfeiture Benefit Rider.** If this optional Rider is selected, the Rider will provide for a period of paid-up long-term care insurance coverage after the Policy lapses after having been in force for 3 years. During this paid-up period, benefits will be payable in the same manner as if the Policy had remained in force, based on the Daily Maximum Benefit(s) in effect at the time of lapse. The Daily Maximum Benefit(s) will not increase after lapse. The total amount payable for claims after the Policy lapses will be limited to the nonforfeiture benefit amount. The nonforfeiture benefit amount will be the lesser of:

(i) One hundred percent (100%) of the total sum of all premiums paid while the Policy was in force; or

(ii) The Policy Lifetime Maximum Benefit, reduced by the sum of all the benefits paid while the Policy was in force and prior to lapse.

Provided that the nonforfeiture benefit amount described above will not be less than:

(i) Thirty (30) times the Nursing Facility Maximum Daily Benefit in effect at the time of lapse if the Policy and this Benefit have been in force for at least 3 years, but less than 10 years; or

(ii) Ninety (90) times the Nursing Facility Maximum Daily Benefit in effect at the time of lapse if the Policy and this Benefit have been in force for 10 years or more.

No benefit is payable under this optional rider if the Policy lapses before it has been in effect for at least 3 years.

e. **Eligibility for Payment of Benefits.**

(1) You will be eligible for payment of benefits provided by the Policy when We determine that You:

(a) Are unable to perform without Substantial Assistance from another individual 2 or more of the Activities of Daily Living due to a loss in functional capacity which is expected to last at least 90 days; or

(b) Have suffered a Severe Cognitive Impairment.

You are considered to be able to perform an Activity of Daily Living if You are able to perform that activity with the aid of equipment, but without the Substantial Assistance of another person.

The Activities of Daily Living include Bathing, Continence, Dressing, Eating, Toileting, and Transferring and are defined as follows:

- Bathing, means washing Yourself by sponge bath or in either a tub or shower, including the task of getting into or out of the tub or shower.
- Continence, means Your ability to maintain control of bowel and bladder functions; or when unable to maintain control of bowel or bladder functions, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag.)
- Dressing, means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
- Eating, means feeding Yourself by getting food into Your body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.
- Toileting, means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- Transferring, means moving into or out of a bed, chair or wheelchair.

Severe Cognitive Impairment means Cognitive Impairment such that You require Substantial Supervision to protect Yourself or others from threats to health and safety. Cognitive Impairment means a deficiency in a person's:

- Short or long-term memory;
- Orientation as to person, place, and time;
- Deductive or abstract reasoning; or
- Judgment as it relates to safety awareness.

The loss or deterioration of intellectual ability is determined using reliable tests and clinical evidence demonstrating the impairment. Loss of intellectual ability can result from Alzheimer's Disease or similar forms of senility or irreversible dementia or other mental illness.

(2) We will confirm Your eligibility by:

(a) Having an Assessment performed at Our request and Our expense to confirm Your functional and cognitive status;

(b) Having You certified by a Licensed Health Care Practitioner as a Chronically Ill Individual;

(c) Reviewing the written Plan of Care prescribed for You by a Licensed Health Care Practitioner insuring that it prescribes the types of care, services or supplies that You need; and

(d) Making sure that the care and services You receive are in accordance with that Plan of Care.

(3) Before any benefit payments are payable:

(a) You must have satisfied the Elimination Period; and

(b) Be receiving care and services that are provided for in the Policy.

(4) Additional Considerations for Payment of Benefits:

(a) No benefits are payable if an Exclusion or Limitation described in the Policy applies.

(b) The benefits We pay under the Policy will count toward the Policy Lifetime Maximum Benefit, except as expressly provided in a Benefit provision.

(c) The care and services for which You claim benefits must be prescribed in a written Plan of Care.

(d) The Policy must remain in force except as provided in the Extended Coverage Benefit.

7. **LIMITATIONS AND EXCLUSIONS.**

a. **Preexisting Conditions.** The Policy while it is in force will pay benefits for Eligible Charges that are the result of preexisting conditions.

b. **Non-Eligible Facilities and Providers.** The Policy will not pay for Eligible Charges that are provided by facilities or providers that do not meet the requirements for that type of facility or provider as described in the Policy.

c. **Non-Eligible Levels of Care.** The Policy does not pay benefits for unlicensed providers, care or treatment provided by immediate family members.

d. **General Limitations and Exclusions.**

(1) Due to war, whether declared or undeclared;

(2) Due to attempted suicide, or any intentionally self-inflicted injury;

(3) As a result of voluntary participation in a riot or attempting to commit an assault or felony;

(4) For care received outside of the United States or its territories except as provided in the World Wide Coverage Benefit;

(5) Which would not be made in the absence of this insurance;

(6) For treatment of alcoholism and drug addiction unless the drug addiction was a result of the administration of drugs as part of treatment by a Physician;

(7) For treatment provided in a government facility unless We are required by law to cover the charges;

(8) For treatment of an injury or sickness which would entitle You to benefits under any state or federal workers' compensation, employers' liability or occupational disease law;

(9) From Family Members unless the Family Member is a regular employee of an organization which is providing the services, and the organization receives the payment for the services; and the Family Member receives no compensation other than the normal compensation for employees in his or her job category;

(10) For *Informal Care* provided by *Family Members* who live in Your home or residence (The Informal Care Benefit is not available in the Nursing Facility and Residential Care Facility Only Insurance Policy);

(11) For prescription drugs, unless You incur such charges while a resident in a Nursing Facility or a Residential Care Facility and the facility charges include such prescription drugs;

(12) To the extent that benefits are payable by Medicare or would be payable except for the application of a deductible or coinsurance amount;

(13) To the extent that benefits are payable under no-fault motor vehicle insurance benefits;

(14) For items of comfort such as toiletries, television rental, beauty and hair charges.

e. **Specific Limitations and Exclusions.**

(1) **Maximum Benefits.** The maximum benefits We will pay are shown on the Schedule of Benefits of the Policy. We will not pay for Home and Community-Based Care on any day that You are confined in a Nursing Facility. Home and Community-Based Care benefits may be paid on any day You are confined in a Residential Care Facility provided the total benefits payable for that day will not exceed the Nursing Facility Maximum Daily Benefit.

(2) **Policy Lifetime Maximum Benefit.** This is the maximum dollar amount that is payable by the Policy during the lifetime of the Policy.

(3) **Chronically Ill Individual Certification.** This is a certification, at least once every 12 months, made by a Licensed Health Care Practitioner, certifying that You are a Chronically Ill Individual per the provisions of the Policy. No benefits are payable unless You are certified as a Chronically Ill Individual.

(4) **Care Not Included in a Plan of Care.** The Policy does not pay benefits for care or services unless such care and services are prescribed in a written Plan of Care prepared by a Licensed Health Care Practitioner.

(5) **Effect of Federal Law.** No benefits are payable under the Policy which would cause the Policy to fail to qualify as a Qualified Long-Term Care Insurance Contract under Sections 7702B(b) of the Internal Revenue Code.

THE POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

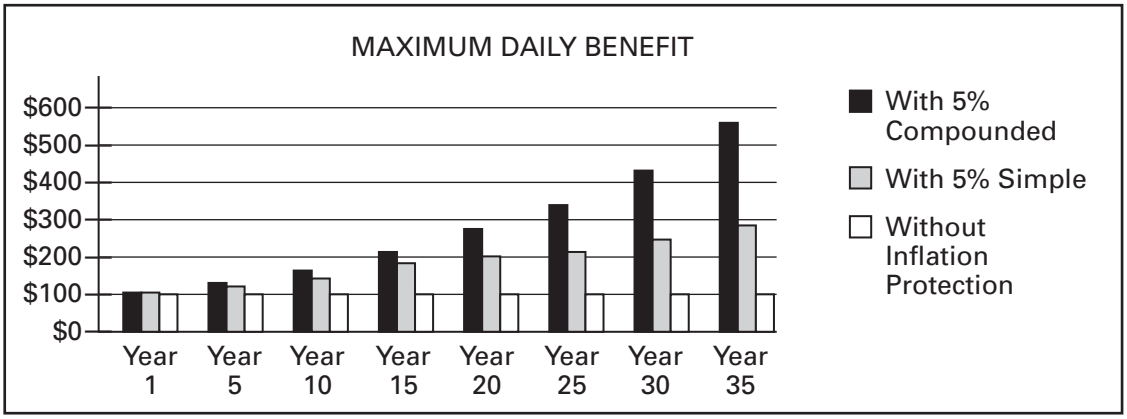
8. **RELATIONSHIP OF COST OF CARE AND BENEFITS.** Because the costs of long-term care services will likely increase over time, You should consider whether and how the benefits of the Policy may be adjusted. Unless You select one of the Compound Annually for Life Inflation Protection Riders, the Simple Increases Annually for Life Inflation Protection Rider, or the CPI-U Benefit Increase Option (all described below), the Policy benefit levels will not increase over time without additional underwriting or health screening.

   a. **3% or 5% Compound Annually for Life Inflation Protection Rider.** If one of these optional riders are selected, We will increase all of the Maximum Daily Benefit(s) and the Lifetime Maximum Benefit(s) on each Policy Anniversary Date while both the Policy and the Rider are in force. Each annual increase will be 3% or 5% of the Maximum Daily Benefits just prior to the increase, depending upon Your selection. All Lifetime Maximum Benefits will be increased by the same percentage. When calculating the Lifetime Maximum Benefits, claims which have been paid will not be considered. Your coverage will increase without additional underwriting or health screening. Your premiums, however, will not increase as a result of the increases provided for by this optional rider. If You do not want the 5% Compound Annually for Life rider You must positively reject the offer in the Acknowledgement section of Your application before You can select any other inflation protection options.

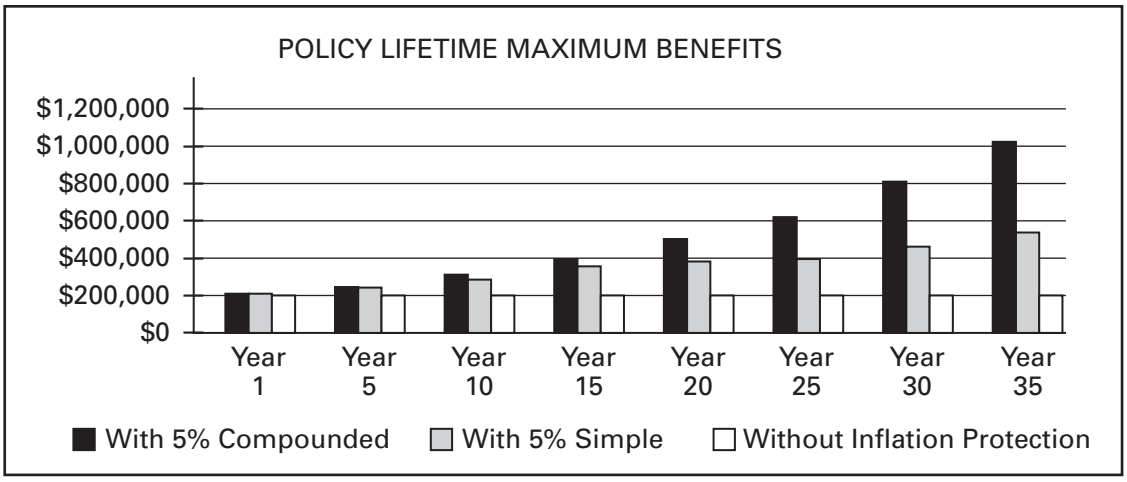
   b. **Simple Increases Annually for Life Inflation Protection Rider.** If the Simple Increases Annually for Life Inflation Protection Rider is selected, We will increase all the Maximum Daily Benefit(s) and the Lifetime Maximum Benefit(s) on each Policy Anniversary Date while both the Policy and this Rider are in force. Each annual increase will be 3%, 4%, 5% or 6% (as You selected) of the original Maximum Daily Benefit(s) at the time this Rider became effective. All Lifetime Maximum Benefits will be increased by the same percentage. When calculating the Lifetime Maximum Benefits, claims that have been paid will not be considered. Your coverage will increase without additional underwriting or health screening. Your premiums, however, will not increase as a result of the increases provided for by this optional Rider. You must positively reject the 5% Compound Annually for Life Inflation Protection Rider before You can select this optional Rider.

   c. **Graphs Illustrating the Effects of Inflation Over Time on Policy Benefits.**

      (1) The following graph compares the effect of the increases in Maximum Daily Benefits due to the optional Inflation Protection Riders, as well as the result of no increases over time.



      (2) The following graph compares the effect of the increases in the Lifetime Maximum Benefits due to the optional Inflation Protection Riders, as well as the result of no increases over time.



d. **CPI-U Benefit Increase Offer Rider.** This Rider provides for annual offers to increase Your Maximum Daily Benefit(s) and Lifetime Maximum Benefit(s) by a percentage. The increases will be effective on the first and each subsequent anniversary of the Rider Effective Date. The percentage increase is determined by subtracting one-hundred percent (100%) from the ratio, expressed as a percentage, of the Consumer Price Index for all Urban Consumers (CPI-U) for all items as determined by the Bureau of Labor Statistics of the United States Department of Labor which was in effect for September of the calendar year immediately preceding the Rider Anniversary at which the option is offered, divided by the CPI-U Index in effect for September of the second calendar year preceding the year of the offer. Your coverage will increase without additional underwriting or health screening. Your premiums will increase as a result of these increases, using Your age at issue to calculate the cost of the additional coverage amount. You must positively reject the 5% Compound Annually for Life Inflation Protection Rider before You can select this optional Rider.

e. **Automatic Compound Annual CPI-U Benefit Increase Rider.** This Rider provides for an automatic annual increase to Your Maximum Daily Benefit(s) and Lifetime Maximum Benefit(s) by a percentage. The increase will be effective on the first and each subsequent anniversary of the Rider Effective Date. The percentage increase is determined by subtracting one hundred percent (100%) from the ratio, expressed as a percentage, of the Consumer Price Index for all Urban Consumers (CPI-U) for all items as determined by the Bureau of Labor Statistics of the United States Department of Labor which was in effect for September of the calendar year immediately preceding the Rider Anniversary at which the option is offered, divided by the CPI-U Index in effect for September of the second calendar year preceding the Rider Anniversary. The minimum increase will be one percent (1%). Your coverage will increase without additional underwriting or health screening. Your premiums will not continue to increase as a result of these increases. You must positively reject the 5% Compound Annually for Life Inflation Protection Rider before You can select this optional Rider.

f. **Notification of New Benefits/Provisions.** We will notify You within 12 months if We develop any new Benefits, new Benefit Eligibility, or new provisions not in Your Policy. To be eligible for an upgrade of Your existing Policy, You must not have filed a claim, be receiving benefits, or be within the Elimination Period of that Policy.

In the event You are eligible for an upgrade, We will offer You the opportunity to upgrade Your Policy, as approved by the California Department of Insurance, subject to Our underwriting requirements for the upgraded coverage, and as may be appropriate in one of the following ways:

- By adding a rider or endorsement to Your Policy, which may or may not have an additional premium, based on Your attained age at that time. The premium for Your original Policy will remain unchanged based on Your age at issue; or
- By replacing Your existing Policy with a subsequent Policy based on Your attained age and subject to a premium credit for past premiums paid; or
- By replacing Your existing Policy with a subsequent Policy based on Your original issue age.

The premium credit for the replacement Policy, issued at Your attained age, shall not be less than 5 percent of the annual premium paid for the prior Policy for each full year the prior Policy was in force, but cumulative credit allowed will not exceed 50 percent.

g. **Requests for Additional Coverage.** You can at any time after the Policy is issued, conditioned on Your continued good health, apply for increases in daily benefit levels and/or increases in Lifetime Maximum Benefits. We will apply our then applicable underwriting standards to evaluate Your insurability for the increased coverage. You may be approved for the additional coverage You applied for, or You may be declined due to a deterioration of Your health. Your premium would increase based on Your attained age for the new coverage approved.

h. **Lower Benefit Plan.** After one year from the Policy Effective Date of this Policy, You have the right to reduce Your premiums by changing to a lower benefit plan.

- Electing a lower Policy Lifetime Maximum Benefit (without changing the Nursing Facility Maximum Daily Benefit, and the Home and Community-Based Maximum Daily Benefit); or
- Reducing the Nursing Facility Maximum Daily Benefit, and the Home and Community-Based Care Maximum Daily Benefit elected as well as the Policy Lifetime Maximum Benefit; or
- Converting to a Nursing Facility and Residential Care Facility Only Insurance Policy.

We will notify You of the options to reduce coverage of the premiums applicable to the reduced coverage and the premiums applicable to the reduced coverage amounts when Your Policy is about to lapse, and whenever the premiums are increased.

The premium payments for the reduced plan will be based on the reduced amount of coverage and Your age as of the Policy Effective Date of this Policy.

9. **TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED.**

a. **RENEWABILITY: THE POLICY IS GUARANTEED RENEWABLE.** This means You have the right, subject to the terms of the Policy, to continue the Policy as long as You pay premiums on time. New York Life cannot change any of the terms of the Policy on its own, except that, in the future, **IT MAY INCREASE THE PREMIUM YOU PAY.**

b. **WAIVER OF PREMIUM.** After You have satisfied the Elimination Period and are receiving benefits under the Policy, the premium payments which become due will be waived. This means that You would not have to pay premiums for the Policy until You are no longer receiving benefit payments. If Your premium payment mode is other than monthly Your premium payment mode will be changed to monthly. If Your premium payment mode is other than monthly when You begin to actually receive benefits, any premium which You have already paid for any coverage during the period for which premiums are waived will be returned to You.

c. **TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.** Changes in Premiums: New York Life has the right to change the premium rates for the Policy. Premium rate increases are subject to Insurance Department approval, will be made only on a class basis and will take effect on a Policy Anniversary Date. We will notify You at least 60 days prior to any premium change.

10. Premiums may also change based on any changes that You request to Benefits as described in the Increases in Benefits and Lower Benefit Plan provisions of the Policy.

11. **ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.** The Policy provides coverage for Alzheimer's disease, other organic brain disorders and all other mental illnesses on the same basis as care and services You receive for any other illnesses covered under the terms of the Policy provisions. This means there is no exclusion in the Policy for mental illness.

12. **PREMIUM**

a. There is an additional cost if You decide to pay premiums other than on an annual basis or once per policy year. The total premium You will pay in a policy year, if You pay more frequently than annually, will be greater than if You pay on an annual basis or once per policy year. The total premium You will pay can be determined by looking at the chart below. For premium payments made more frequently than annually (semi-annually, quarterly, and monthly), multiply the annual premium by the following percentages:

Payment Frequency	**Percentage of Annual Premium**
Semi-annual:	51%
Quarterly:	26%
Monthly:	9%

For example, if the annual premium is $1,000, and You elect to pay semi-annually, You will make two payments of $510 (.51 X $1,000 = $510) during the policy year for a total of $1,020 ($510 + $510) or $20 more than if You paid on an annual basis or once per policy year.

b. The annual premium for the Policy with the benefits and premium payment frequency You selected is:

Applicant $ _____ Spouse $ _____

c. The annual premium for the policy and additional benefits is:

Applicant $ _____ Spouse $ _____, which consists of:

	Applicant	Spouse
Base Policy	_____	_____
Inflation Protection	_____	_____
Shared Care Rider	_____	_____
Couples Rider	_____	_____
Return of Premium Upon Death Benefit Rider	_____	_____
Nonforfeiture Rider	_____	_____

13. **Medical Underwriting for the Policy is based on Your Health Status.** Experienced underwriters will determine whether Your Application will be approved by reviewing Your Application, Eligibility Questions and Health Statement. The Physicians You list in Your Application may be contacted to provide information about Your health, including copies of Your medical records. We may also ask You additional questions by telephone, personal interview and/or written questionnaire. We have the right to request additional underwriting information, as well as to decline to cover individuals who, in our opinion, do not meet Our underwriting requirements. Your application will be reviewed and if a declination is appropriate, such declination will be on a non-discriminatory basis.

14. **INFORMATION AND COUNSELING.** The California Department of Insurance has prepared a Consumer Guide to Long-Term Care Insurance. This guide can be obtained by calling the California Department of Insurance toll-free number. This number is 1-800-927-HELP. Additionally, the Health Insurance Counseling and Advocacy Program (HICAP), administered by the California Department of Aging, provides Long-Term Care Insurance counseling to California senior citizens. Call the HICAP toll-free number 1-800-434-0222.

Information about Your Local HICAP office provided by Your agent:

Local HICAP office address: _____
Street Address

_____
City, State Zip

Local HICAP office telephone number: _____

THINGS YOU SHOULD KNOW BEFORE YOU BUY LONG-TERM CARE INSURANCE

NEW YORK LIFE INSURANCE COMPANY
51 Madison Avenue, New York, NY 10010

To be retained by APPLICANT(S)

LONG-TERM CARE INSURANCE

- A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
- You should not buy this insurance unless you can afford to pay the premiums every year. Remember that the company can increase premiums in the future.
- The Long-Term Care Insurance Personal Worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

MEDICARE

- Medicare does not pay for most long-term care.

MEDICAID (MEDI-CAL in California)

- Medi-Cal will generally pay for long-term care if you have very little income and few assets. You should **not** buy this policy if you are now eligible for Medi-Cal.
- Many people become eligible for Medi-Cal after they have used up their own financial resources by paying for long-term care services.
- When Medi-Cal pays your spouse's nursing facility bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
- Your choice of long-term care services may be limited if you are receiving Medi-Cal. To learn more about Medi-Cal, contact your local or state Medi-Cal agency office.

SHOPPER'S GUIDE

- Make sure the insurance company or producer gives you a copy of a booklet called "Taking Care of Tomorrow, A Consumer's Guide to Long-Term Care," prepared by the California Department of Aging. Read it Carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

COUNSELING

- The California Department of Insurance has prepared a Consumer Guide to Long-Term Care Insurance. This guide can be obtained by calling the California Department of Insurance toll-free number. This number is 1-800-927-HELP. Additionally, the Health Insurance Counseling and Advocacy Program (HICAP), administered by the California Department of Aging, provides Long-Term Care Insurance counseling to California senior citizens. Call the HICAP toll-free number 1-800-434-0222 for referral to your local HICAP office.

FACILITIES

- Some long-term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move to a different state from where they purchased their long-term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchase the policy.

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LONG-TERM CARE INSURANCE
POTENTIAL RATE INCREASE DISCLOSURE FORM

NEW YORK LIFE INSURANCE COMPANY
51 Madison Avenue, New York, NY 10010

To be retained by the APPLICANT(S)

This Potential Rate Increase Disclosure Form is being provided to you to give you information on premium rate schedules, rate schedule adjustments, potential rate revisions, and your options in the event of a premium rate increase on your long-term care insurance policy. New York Life Insurance Company is required to provide this important information to you.

1. **Premium Rates:** Premium rates that are applicable to you are shown initially on your application. Once your Policy is issued the premium rates applicable to you for your age and rate classification at issue are shown on the Schedule of Benefits page of your Policy. Those premium rates are applicable to you and will remain in effect until a request is made by New York Life Insurance Company to the department of insurance in your state and filed by or approved by that agency, if required.
2. **The premium rate for your Policy will be shown on the Schedule of Benefits page of your Policy.**
3. **Rate Schedule Adjustments:** New York Life will provide you with a written notice at least 60 days prior to any premium rate increase with the rate increase becoming effective on a Policy Anniversary Date.
4. **Potential Rate Revisions: This policy is Guaranteed Renewable.** This means that the rates for this product may be increased in the future. Your rates can **NOT** be increased due to your increasing age or declining health, but your rates may go up based on the experiences of all Insureds with a policy similar to yours in your state.

If you receive a premium rate increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

- Pay the increased premium and continue your policy in force as is.
- Reduce your Policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
- Exercise your optional nonforfeiture benefit if purchased. (This option is available for purchase for an additional premium.)
- Exercise your contingent nonforfeiture rights. * (This option is available if you do not purchase a separate optional nonforfeiture benefit.)

***Contingent Nonforfeiture**

If the premium rate for your Policy goes up in the future and you did not buy the optional nonforfeiture benefit, you may be eligible for contingent nonforfeiture. Here is how to tell if you are eligible:

You will keep some long-term care insurance coverage under your contingent nonforfeiture benefit, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new policy lifetime maximum benefit amount) you will keep will equal the total amount of premiums you have paid since your Policy was first issued. If you have already received benefits under your Policy, so that the remaining maximum benefit amount is less than the total amount of premiums you have paid, the amount of coverage will be that remaining amount.

Except for this reduced policy lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose to exercise this contingent nonforfeiture benefit, your Policy, with this reduced maximum benefit amount, will be considered “paid-up” with no further premiums due.

Example:

- You bought your Policy at age 65 and paid the $1,000 annual premium for 10 years, so you have paid a total of $10,000 in premium.
- In the eleventh year, you receive a rate increase of 50%, or $500 for a new annual premium of $1,500, and you decide to lapse this Policy (not pay any more premiums).
- Your "paid-up" Policy benefits are $10,000 (provided you have at least $10,000 of benefits remaining under your Policy).

The purchase of additional coverage shall not be considered a premium rate increase, but for purposes of the calculation of the ratio below of Cumulative Premium Increase Over Initial Premium, the portion of the premium attributable to the additional coverage shall be added to and considered a part of the initial annual premium. A reduction in benefits shall not be considered a premium change, but for purposes of the calculation of the ratio, the initial annual premium shall be based on the reduced benefits.

Contingent Nonforfeiture
Cumulative Premium Increase Over Initial Premium
That Qualifies for Contingent Nonforfeiture
(Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)

Issue Age	Percent Increase Over Initial Premium	Issue Age	Percent Increase Over Initial Premium
29 and under	200%	72	36%
30-34	190%	73	34%
35-39	170%	74	32%
40-44	150%	75	30%
45-49	130%	76	28%
50-54	110%	77	26%
55-59	90%	78	24%
60	70%	79	22%
61	66%	80	20%
62	62%	81	19%
63	58%	82	18%
64	54%	83	17%
65	50%	84	16%
66	48%	85	15%
67	46%	86	14%
68	44%	87	13%
69	42%	88	12%
70	40%	89	11%
71	38%	90 and over	10%

NEW YORK LIFE INSURANCE COMPANY
51 Madison Avenue, New York, NY 10010

To be retained by the APPLICANT(S)

HIPAA NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice applies to New York Life's long-term care insurance product, which is covered by the Health Insurance Portability and Accountability Act ("HIPAA"). It provides our long-term care customers with detailed information about our privacy practices concerning your personal health information, including:

- Our obligations concerning the use and disclosure of your personal health information; and
- Your privacy rights regarding your personal health information.

You may receive additional privacy notices from us. Those notices are provided in accordance with other laws and regulations, and describe our practices with respect to personal and financial information in addition to medical information.

If you have questions about this Notice or need further assistance, please contact us at:

New York Life Insurance Company
51 Madison Ave.
New York, NY 10010
Telephone: 1-800-224-4582

NEW YORK LIFE WILL NOT USE YOUR PERSONAL HEALTH INFORMATION OR DISCLOSE IT TO OTHERS UNLESS DOING SO IS NECESSARY AND ALLOWED BY LAW. THE FOLLOWING DESCRIBES HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION.

When you provide an authorization. Except as described in this Notice, we will not use or disclose your personal health information without written authorization from you. You may revoke in writing any authorization you provide regarding the use and disclosure of your personal health information. After you revoke your authorization, we will no longer use or disclose your personal health information for the reason described in the authorization, except in the following situations:

- If we have taken action in reliance on your authorization before we received your written revocation;
- If you were required to give us your authorization as a condition of obtaining insurance; or
- If state law gives us the right to contest a claim under your policy.

For your treatment. We may disclose your personal health information to others who may assist with the long-term care or other health services you may receive such as:

- A physician, professional nurse or other health care provider, or
- Your spouse, children or parents.

To family and friends helping with your care. With your approval, we may share your personal health information with a friend or family member who is helping to care for you, or to pay for your health care or related services.

- If you are unavailable, incapacitated or facing an emergency medical situation, and we determine it is in your best interest, we may share limited personal health information with these individuals without your approval.
- If you have designated someone to receive information regarding payment of the premium on your policy, we will inform that person when your premium has not been paid.
- We may also share limited personal health information with a public or private entity that is authorized to assist in disaster relief efforts, such as to help us locate a family member or friend who may be involved in caring for you.

To verify that covered services were provided or to obtain payment. For example, we may contact your health care provider to certify that you received services, and we may request details regarding the services received to process and pay claims. We also may need to use your personal health information to obtain payment from third parties that may be responsible for your premium payments, such as family members.

To provide quality products and services and operate our business. Examples include providing customer service, underwriting your coverage, resolving claims and grievances, activities relating to the creation, renewal or replacement of an insurance policy, auditing, and ensuring compliance with HIPAA and other legal requirements. Be assured that in each instance we will use and disclose only the minimum information necessary to perform these functions.

To ensure that our agents and contractors can perform required services. As part of operating our business, we rely on our agents and on certain outside firms and individuals with whom we have entered into contracts. At times, we may need to provide your personal health information to one or more of these to assist us in ensuring your coverage or in connection with your payments or our business operations. Often, the information we disclose is limited to non-medical information such as billing status or the fact that you own a policy with us. The law treats this type of information as "health information," even though it does not refer to your health status or medical conditions. In all cases, we disclose only the minimum information necessary for these business associates to perform their responsibilities, and we require them to appropriately safeguard your information. Examples of these business associates include:

- Our licensed insurance agents
- Care assessment agencies
- Underwriting services
- Reinsurers
- Legal services
- Enrollment and billing services
- Claim payment and collection services

So we may inform you of other benefits and services. From time to time, we may consider your personal health information in determining whether to provide information to you concerning enhancements to your long-term care insurance policy or to offer enhancements to your current coverage as permitted by HIPAA.

When required or permitted by law. We may disclose your personal health information without your authorization when required or permitted by law such as:

- If required to do so by a court or administrative subpoena or discovery request;
- If we believe you to be a victim of abuse, neglect or domestic violence;
- As required by armed forces officials if you are a member of the military;
- To workers' compensation agencies if necessary for your workers' compensation benefit determination;

- If required or permitted by law to a government oversight agency conducting audits, investigations, or civil or criminal proceedings or to insurance regulatory authorities;
- To protect the public health, such as required reporting of disease or injury, and for required public health investigations;
- To law enforcement agencies or national security officials to help prevent fraud, unlawful activity, and to report crimes; or
- To a coroner or medical examiner, a funeral director, or for organ or tissue donation purposes.

When your authorization is required. Your prior written authorization would be required before we could use or disclose psychotherapy notes. We would also need to obtain your prior written permission if your personal health information were to be used for marketing or sales purposes.

Your rights regarding your personal health information. It is important to us that you understand that you have certain rights regarding the personal health information we maintain about you. To exercise any of your rights, just contact us at the location listed on the cover of this Notice.

You have the right to specify how we communicate with you. For instance, you may ask that we contact you at home, rather than at work. To make such a request, all you have to do is tell us your preferred means of communication; we will accept all reasonable requests.

You have the right to request a restriction on our use or disclosure of your personal health information.

- To do so, just send a request in writing. Please provide specific details concerning the restrictions you are requesting. We will grant all reasonable requests. If we agree to a restriction, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary for your treatment.
- We retain the right to terminate a restriction if we believe it is necessary and appropriate, but we will notify you before doing so.

You have the right to inspect and/or obtain an electronic or hand copy of your personal health information. This includes underwriting, payment and claim records, but does not include certain records such as psychotherapy notes or records prepared in connection with legal proceedings or fraud investigations. You may also send a written request designating another individual to receive your personal health information on your behalf. Written requests must be signed and dated by you or your personal representative and must clearly identify the individual to receive your personal health information and his/her contact information. In the unlikely event that we do deny your request, you may obtain a review of our denial. We may charge a fee for the costs of copying, mailing, labor and supplies associated with your request.

You may ask us to amend your health information if you believe it is incorrect or incomplete. We are not required to make all requested amendments but will give each request careful consideration.

- Requests must be in writing, signed by you or your representative, and must state the reasons for the amendment.
- If the information you want to amend is in medical records we have received, you will need to speak to the doctor or other provider who wrote the record and ask that he or she make the change. You can then have your doctor or provider send a copy of the revised records to us at the address above.

You have the right to request an "accounting of disclosures." An accounting of disclosures lists disclosures we have made of your personal health information outside of treatment, payment or business operations.

To obtain an accounting, submit a written request.

- All requests must identify the time period, which may not be longer than six years and may not include dates before April 14, 2003.
- The first list you request within a 12-month period is free of charge. We will let you know if any costs will be involved, and you may withdraw your request before you incur any costs.

You are entitled to receive notification of unauthorized access to your personal health information. We maintain physical, electronic and procedural safeguards to protect our customers' personal information that are compliant with all applicable federal and state laws. However, if your personal information is ever compromised, we will notify you of the incident.

You have the right to file a complaint. If you believe your privacy rights have been violated, it is your right to file a written complaint with us or write the Secretary of Health and Human Services. Complaints filed with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C. must be submitted within 180 days of the suspected violation. **You will not be retaliated against for filing a complaint.**

INFORMATION ABOUT THIS NOTICE

We hope that you will find this description of our medical information privacy practices helpful. Protecting your personal health information is of the utmost importance to us, and we want you to know that we do not share your personal health information other than as described in this Notice.

If your state provides privacy protections more stringent than those provided by HIPAA, we will maintain your personal health information in accordance with the more stringent state standard.

We reserve the right to revise or amend this Notice. Any revision or amendment to this Notice will be effective for all of your records, whether they were created or maintained in the past or in the future. If we do change the information in the Notice, copies of revised Notices will be mailed to all policyholders. Of course, you may request a copy of our current Notice at any time.

EFFECTIVE DATE

This notice is effective June 1, 2013.

NEW YORK LIFE INSURANCE COMPANY
51 Madison Avenue, New York, NY 10010

To be retained by the APPLICANT(S)

Information Practices Related to Underwriting Your Application

New York Life Insurance Company
51 Madison Avenue, New York, NY 10010

New York Life Insurance and Annuity Corporation (NYLIAC) (A Delaware Corp.)
51 Madison Avenue, New York, NY 10010

NYLIFE Insurance Company of Arizona (NYLAZ) (Not licensed in every state) *
4343 North Scottsdale Road,
Suite 220, Scottsdale, AZ 85251

*NYLAZ is not authorized in New York and Maine, and does not do any insurance business in New York or Maine.

What You Should Know About Your Application For Insurance

The application that has been completed with your agent is the starting point to obtaining your insurance policy. The application gathers detailed information that is necessary to evaluate prior to issuing a policy. This information will be entered into our computer systems to start the risk assessment and classification process known as "underwriting."

The underwriting process enables the company to determine: (1) if the coverage will be approved; and (2) the appropriate premium for the insurance coverage requested.

Information Gathered During the Underwriting Process

Once the underwriting process begins, we take into account a variety of factors and sources of information, including your application responses and information from outside sources, such as public records. We may perform any of the following activities:

Medical History and Requirements

You may be asked to have: (1) laboratory tests; (2) a medical exam; (3) an ECG; or (4) other medical tests as part of your application for insurance. In some cases, we may need to obtain medical records from a health care provider whom you may see or have seen. New York Life will pay for the expense of these tests, as well as the cost of obtaining the medical records.

Telephone Interview Report

For quality assurance reasons, we may have a New York Life representative contact you by telephone to supplement or confirm information on the application. Please be prepared to discuss items like your employment, medical history, finances, hobbies, etc.

Consumer Reports

We may obtain information from consumer reporting agencies that bear on an applicant's credit standing, character, general reputation, personal characteristics or mode of living. In some situations, an "investigative consumer report" and/or prescription drug history may be requested, which will supplement information on the application. You may request to be interviewed regarding preparation of an investigative consumer report. Upon request, you are entitled to receive a copy of the report. State and Federal Fair Credit Reporting Acts require us to give U.S. residents the notice that follows:

Notice

You are entitled to know that, as part of our regular procedures, we may request an investigative consumer report concerning the insurability of each person proposed for coverage. This report would include information as to: (1) character; (2) general reputation; (3) personal characteristics; and (4) mode of living. This information would be obtained through personal interviews with: (1) friends; (2) neighbors; and (3) associates of the proposed insured. It will not include any information relating to the proposed insured's sexual orientation.

If you would like more information, we will be glad to supply a complete and accurate disclosure of the nature and scope of the investigative consumer report. We must receive your written request within a reasonable period of time. To facilitate our prompt reply, please send any such request to our local General Office. The address can be provided by our agent. Include with your request: (1) the name of the agent; (2) your own full name; (3) your date of birth; and (4) your return address.

The consumer reporting agencies we may use in the event we request an investigative consumer report are:

Examination Management Services Inc. (EMSI)
2925 LBJ Freeway #140
Dallas, TX 75234
Phone: (800) 530-0560

Lab One/Choice Point*
Consumer Disclosure Unit
1000 Alderman Drive
Alpharetta, GA 30005
Phone: (800) 456-6004

DAC Services*
4500 South 129th East Avenue
Suite 200
Tulsa, OK 74134
Phone: (800) 381-0645
(* Motor vehicle reports only)

The proposed insured may obtain a copy of the investigative consumer report from the consumer reporting agency either in person or through the mail. Certain information about the report may be provided to the proposed insured by telephone if the proposed insured has made a written request to the consumer reporting agency for telephone disclosure and has provided proper identification, such as a valid driver's license or Social Security account number. The consumer reporting agency will provide trained personnel to explain the investigative consumer report and coded information it may obtain.

Information Exchange with MIB, Inc. (Medical Information Bureau)

MIB is a non-profit membership corporation. It operates an information exchange on behalf of member insurance companies. As a member company, New York Life will ask MIB to check its file to see if there are: (1) any previous requests for insurance; or (2) claims for disability income benefits.

All information obtained during the underwriting process will be treated as confidential. The company may make a brief report to MIB. The report may include data that affects your insurability, including data about any life insurance policy(ies) the company issues on you. If you have a question about the accuracy of the information MIB has on file, a request can be made to them directly. MIB will disclose its information on file to you. If there is a discrepancy, you may seek a correction to the information. All requests will be handled in accordance with the procedures set forth in the Fair Credit Reporting Act.

The address for the information office of MIB, Inc. is:

50 Braintree Hill Park, Suite 400
Braintree, MA 02184-8734
Telephone number: (866) 692-6901
(for hearing impaired TTY (866) 346-3642)

In Canada, the address is:

330 University Avenue, Suite 501
Toronto, Ontario, Canada M5G 1R7
Telephone number: (416) 597-0590

Information for consumers about MIB may be obtained on its website at www.MIB.com.

Access and Correction of Recorded Information

You may contact New York Life at the address below concerning discrepancies on any of the consumer report information gathered during the underwriting process. We will provide you with: (1) the name; (2) address; and (3) phone number of the consumer reporting agency that prepared the report. You may obtain a copy of that report from the reporting agency.

You also have the right of access to certain personal information we maintain in our files about you, including the specific reason(s) for an adverse underwriting decision. Generally, medical record information will be given either directly to the proposed insured or to a medical professional designated by the proposed insured. You may request: (1) a correction; (2) an amendment; or (3) deletion of any information to which you have access. You can receive a description of these rights by writing to:

New York Life Insurance
Home Office Underwriting Department
51 Madison Avenue
New York, NY 10010

Delivery of Your New York Life Policy

Once the underwriting process is completed and a policy is approved, your agent will deliver your New York Life policy. At that time, you will need to sign a delivery receipt along with any other required forms to put your policy "in force." You should review your policy and the application included in the policy for accuracy.

If there are any: (1) questions; (2) errors; or (3) missing information, you should discuss this with your agent promptly. We also request that you keep your policy in a safe place.

Application Instructions for Producers

Please be sure to complete the application legibly and completely. Incomplete applications may result in a processing delay.

An application will not be processed if:

- The Social Security Number is omitted
- The Applicant(s) initials are omitted beside a cross-over or correction
- White-out appears anywhere on the application
- Signatures or dates are omitted
- The Acknowledgement box on the Personal Worksheet is not checked.

These help symbols appear in the lower right of corner where important instructions apply.

- Applicant(s) signature required

- Producer signature required

- to be completed and returned to LTC Service Center

- to be retained by Applicant(s)

Application submissions, including all applicable forms and payment, can be submitted via your general office, regular mail or express mail.

General Office	Regular mail	Express mail
Submit to your GO admin team for overnight delivery to the LTC service center	New York Life LTC PO Box 64670 St. Paul, MN 55164-0670	New York Life LTC 7805 Hudson Rd, Ste. 180 Woodbury, MN 55125

The fastest way to have new business insured is for you to fill out the application and associated documents completely and properly. Please be sure to complete all areas of the application and associated documents legibly and completely.

Important Privacy Choices for Consumers – Form 22526CA is required to be completed for each Applicant for insurance if the Applicant(s) do not want personal information shared. The document allows the Applicant to control the use of personally identifiable information by the Company. The signed form needs to be returned to New York Life, PO Box 539, Dallas, TX 75221.

Outline of Coverage – The Outline of Coverage provides a brief description of the policy benefits and features and must be delivered to the Applicant(s) at the time of solicitation. There are two areas of this form that you MUST complete before you leave this document with the Applicant(s).

Section 11 – Premium – Complete this section with the information on the coverages the Applicant(s) is/are purchasing including information regarding optional benefits.

Section 13 – Local HICAP Office Information – California requires that you complete the local HICAP information for the Applicant(s). A listing is provided to you, but the information may also be located on the CA Department of Aging website at www.aging.ca.gov.

The Outline of Coverage is retained by the Applicant(s).

Things You Should Know Before You Buy Long-Term Care Insurance – New York Life is required to deliver to each Applicant for long-term care insurance this disclosure form describing long-term care insurance, Medicare, Medicaid (Medi-Cal in California), a shoppers guide and insurance counseling information.

Long-Term Care Insurance Personal Worksheet – New York Life is required to evaluate the suitability of any long-term care purchase in California. The tool used is the Long-Term Care Insurance Personal Worksheet. The Applicant(s) need(s) to provide financial and other information for the suitability of the purchase to be determined.

Incomplete Personal Worksheet(s) will result in 1) the application being pended until the information is received, or 2) a suitability letter to be generated to the Applicant(s).

If the Applicant(s) elect(s) not to provide financial information, a letter will be sent to the Applicant(s) advising that the company is required to evaluate the suitability of the purchase. The Applicant(s) can sign the second page of the letter requesting that underwriting continue regardless of the suitability of the purchase. The action of the Applicant(s) is waiving New York Life's obligation to evaluate the suitability of the purchase.

The second page of the letter must be received in the Long-Term Care Division offices within 60 days of the date of the letter. If the letter is not returned within the 60-day period the application will be returned and any premium paid refunded.

No policy acceptance action can be accomplished until the letter is returned.

Items to consider when completing the Personal Worksheet:

Premium Information – Complete the premium information for the Applicant(s) based on the policy benefits selected and indicate the premium mode.

Rate Increase Information – Although no response is necessary in this section, the fact that the policy is guaranteed renewable and the fact that premium increase may occur in the future needs to be covered with the Applicant(s).

A rate guide is available and can be obtained from the California Department of Insurance or viewed on the Department of Insurance's website: www.insurance.ca.gov

Questions Related to Your Income – Check the box to indicate where the funds for the premium payments will be coming; either from income, assets/investments or someone else will be paying the premiums.

The question to the Applicant(s) consideration of can he/she still afford the policy even if a rate increase of for example 20% must be checked. **Failure to answer this question will delay the processing of the application.**

The annual income and the prediction of whether income will increase, stay the same, or decrease over the next 10 years are important questions. The income provided here is used to determine if the premium exceeds 7% of the income as one of the financial suitability checks.

Inflation Protection – Complete this section to determine how the Applicant(s) plan(s) to handle increases in the cost of long-term care due to inflation.

Elimination Period – How to fund the cost of care during the elimination period is something that the Applicant(s) should consider. The number of days selected for the elimination period times the nursing home maximum daily benefit is the approximate cost of the care during the elimination period. The answer to the question of how the Applicant(s) plan(s) to cover the cost of care during the elimination period is key to the Applicant(s) understanding that the elimination period is like a deductible.

Questions Related to Your Savings and Investments – The Applicant(s) is/are asked to provide the estimated value of savings and investments and if the savings and investments will increase, stay the same or decrease over the next 10 years. The value of the savings and investments will be used as the asset component of suitability of purchase determination.

Disclosure Statement – One of the two questions MUST be answered. If the Applicant(s) decline(s) to provide financial information, a suitability letter will be mailed to the Applicant(s). The Applicant(s), by indicating on the second page of that letter that he/she wants underwriting to continue regardless of the suitability of the purchase, waives New York Life's obligation to evaluate the suitability of the purchase.

Acknowledgement – The box in this section MUST be checked in every case. If the box is not checked the Personal Worksheet is not complete and underwriting will be delayed.

Signature of Applicant(s) – The Applicant(s) must sign the form regardless if financial information was provided or not.

Signature of Producer – The producer must sign the form regardless if financial information was provided or not.

Application – The following descriptions and comments are designed to assist in the accurate completion of the application.

Part I – Applicant Information – Complete all requested information and answer all questions to provide Applicant personal information.

Part II – Spouse Information – Complete all requested information and answer all questions to provide spouse information if the spouse is applying for coverage.

Part III – Policyowner Information – Do not complete. The insured is the policyowner.

Part IV – Plan Selection – Select only one feature/ benefit in each category as described below.

Nursing Facility Maximum Daily Benefit (NFMDB) ($100 to $400)

Select the Benefit Period and the Policy Lifetime Maximum Benefit (NFMDB times benefit period multiplier) – To obtain the Policy Lifetime Maximum Benefit multiply the NFMDB times the number of days in the benefit period selected. The multipliers are 730 days = 2 years, 1095 days = 3 years, 1460 days = 4 years and 1825 days = 5 years, 2555 days = 7 years or 3650 days = 10 years. The unlimited benefit period is pre-filled with "Unlimited".

Home and Community-Based Care Maximum Daily Benefit – To obtain the Home and Community-Based Care Maximum Daily Benefit multiply the selected HCBC percentage times the NFMDB. The percentages available are 50%, 60%, 70%, 80%, 90% and 100%. The Home and Community-Based Care benefit is not available if the insured purchases the Nursing Facility and Residential Care Facility Only Insurance Policy. **The Home and Community-Based Care Maximum Daily Benefit must be at least $50.**

Elimination Period – Check a box to select the elimination period.

Inflation Protection Type – Check a box to select the appropriate inflation protection option.

Couples Additional Benefit Rider – Check the box to select this optional benefit or leave the box blank if this optional benefit is not desired. There is an additional premium to include this benefit rider. REMEMBER: Both spouses must have identical effective dates and identical coverage to be able to select this benefit. Also, benefits must remain the same during the life of the policy or this rider will terminate.

Shared Care Rider – Check the box to select this optional benefit or leave the box blank if this optional benefit is not desired. There is an additional premium to include this benefit rider. REMEMBER: Both spouses must have identical effective dates and identical coverage to be able to select this benefit. Also, benefits must remain the same during the life of the policy or this rider will terminate.

Return of Premium Upon Death Benefit Rider – Check the box to select this optional benefit or leave the box blank if this optional benefit is not desired. There is an additional premium to include this benefit rider.

Optional Nonforfeiture Benefit Rider – Check the box to select this optional benefit or leave the box blank if this optional benefit is not desired. There is an additional premium to include this benefit rider. If this rider is not selected in the application or is later deleted from the policy, a Contingent Nonforfeiture Benefit Rider will be added to the Policy at no additional cost to the insured.

Part V – Eligibility Questions – The eligibility questions must all be answered. If any question or part of a question is not answered, the application will be returned as incomplete. Also, **"yes" answers to any question of this Part V will disqualify that person for coverage.**

Part VI – Health Statement Questions – The health statement questions must all be answered. If any question or part of a question is not answered, the application will be returned as incomplete.

The medications prescribed for the health questions, physician and prescribing physician information are extremely important to the obtaining of medical records. Be sure to list all physicians and/ or prescribed medications for the Applicant(s)

including the name of the physician, specialty, address and telephone number of the physician.

Part VII – Physician and Medication Information – List all prescription medications taken by the Applicant(s) and include prescribing physician information. Be sure that prescribing physician name, specialty, address, and telephone number as well as the medication prescribed by that physician for the Applicant(s) is complete.

Part VIII – Underwriting Information – Answer all questions providing additional information used in the underwriting process. Do not leave any question unanswered.

Part IX – Other Insurance Information – Answer all questions providing information on other insurance the Applicant(s) may have in force as well as any insurance that may have lapsed in the last 12 months. These are referred to as "Replacement Questions" and must be answered. If a replacement is involved, then the name of the existing carrier is required. If New York Life is the existing carrier of the policy being replaced, the transaction is considered an internal replacement and must conform to published internal replacement requirements.

If the person is covered by Medicaid (Medi-Cal in California), then the purchase of the long-term care insurance is usually not appropriate.

Part X – Protection Against Unintended Lapse – Applicant(s) must check one of the two boxes.

The first check box is for the Applicant(s) to **DESIGNATE** another person (Third Party Designee) to receive a notice of policy termination in addition to the insured if the termination reason is non-payment of premium. If the first box is checked, then the name and address of that Third Party must be completed. The insured will be notified no less frequently than once every two years of their right to change the Third Party.

The second check box is for the Applicant(s) to **DECLINE TO DESIGNATE** another person (Third Party Designee) to receive a notice of policy termination in addition to the insured if the termination reason is non-payment of premium.

The signatures of the Applicant(s) in Part XI – Acknowledgements confirms the designation or acknowledges the waiver to not designate.

Part XI – Acknowledgements – The signatures in this part provides the overall acknowledgement that all the answers are true and complete to the best of the Applicant(s') knowledge and belief; agreement to a personal interview for underwriting purposes; agreement with the terms of the conditional receipt that no coverage will be in effect until the application is approved; selection of a third party designee or decline to designate such a designee; and acknowledgement that producer cannot determine eligibility for coverage or alter the terms of the policy.

The "Application signed at" blank requires the city and state where the application is signed. This location will determine the state of solicitation and the state where the policy is to be delivered.

Part XII – Checklist – The checklist is required by California rules to ensure that consumers are receiving the information that is necessary to make an informed purchase decision and to provide appropriate disclosures to the consumer(s).

The Applicant(s) and producer must sign acknowledging the Applicant(s') answers to the following items:

Receipt of the following:

Taking Care of Tomorrow, A Consumer's Guide to Long-Term Care

Guide to Health Insurance for People with Medicare

Outline of Coverage

HICAP Contact Information (producer provided on the last page of the Outline of Coverage)

Things You Should Know Before Your Buy Long-Term Care Insurance

Potential Rate Increase Disclosure Form

Notice to Applicants Regarding Information Practices (Important Privacy Choices for Consumers, Privacy Policy, HIPAA Notice of Privacy Practices; and Information Practices Related to Underwriting Your Application)

Acknowledgement of the following:

That the Outline of Coverage for the plan being applied for has been reviewed.

Of the review and completion of the Long-Term Care Insurance Personal Worksheet.

That if the policy is a replacement that the Notice to Applicant Regarding Replacement of Accident and Sickness or Long-Term Care Insurance has been received.

The Applicant(s) and producer must sign and date this part.

Part XIII – Payment Mode and Authorization for Automatic Payment Options – Indicate the payment type; direct bill; automatic payment option or payroll deduction (for New York Life approved employers only).

Please note that regardless of payment mode or payment type, do not submit more than one month premium with the application per California regulations.

Direct Bill – The options available are annual, semi-annual and quarterly. Monthly direct bill is not available.

Automatic Payment Options – The following are the available automatic payment options:

Monthly Electronic Funds Transfer (EFT) – EFT provides a debit from the insured's bank account on a monthly basis on the day of the month of the policy effective date (draft date). If EFT is selected, then the Applicant(s) must sign the Automatic Payment Option Authorization in this part.

If EFT is selected and the Applicant(s) is/are approved for coverage, any premiums due from the effective date of the policy to the next draft due date after the Policy Delivery Receipt is received by our Policyowner Service department, will be drafted on the draft date following our receipt of the Policy Delivery Receipt. Since several months may have passed since the application was signed, the draft from the insured's account could be for more than one month's premium. This procedure should be explained to the Applicant(s) as the Applicant(s) signs in this part.

Payroll Deduction - If Payroll Deduction is the selected method of premium payment, then the signature in the Automatic Payment Option Authorization, would enable the employer to process the deduction of premium payments and remitting premium payments to New York Life.

HIPAA Medical Authorization (Long-Term Care Insurance Medical Authorization) – All New York Life application forms submitted are subject to underwriting, which would require the request of medical records for physician/medication information. The HIPAA Medical Authorization is compliant with the HIPAA requirements. Some entities such as some Kaiser plans require that for release of medical records, the Applicant(s) must sign a medical authorization created for or by that entity. Applications will not be processed without a HIPAA compliant medical authorization complete for each applicant and signed by that applicant.

Notice Regarding Replacement of Accident and Sickness or Long-Term Care Insurance (Replacement Notice) – If a replacement is involved or if the producer suspects that the Applicant(s) will lapse or otherwise terminate health or long-term care insurance with the purchase of this policy, two copies of the Replacement Notice must be completed and signed by both the producer and Applicant(s). One copy, designated by "APPC" in the form number in the lower left of the form, is to be retained by the Applicant(s). The second copy, designated by "COC" in the form number, is to be returned with the application.

Conditional Receipt – Complete the conditional receipt including the amount of premium collected from the Applicant(s). The conditional receipt must be signed by the producer and left with the Applicant(s).

Producer Statement and Certification – See form ILTC-5101-PC (0109). The producer indicates if he/she actually witnessed the signature(s) in the application and certifies to understanding and compliance with various solicitation requirements. The producer must sign this form.

Producer Provided Information – The information provided in this part provides required replacement information as well as information about the type of dwelling where the Applicant(s) live(s).

Question 1 – The list of health policies the producer has sold to the Applicant(s) that are still in force is a replacement requirement, but MUST be answered in all cases.

Question 2 – The list of health policies that the producer sold to the Applicant(s) within the past five years that have lapsed is a replacement requirement and MUST be answered in all cases.

Question 3 – Indicate if the producer knows or is reasonably expected to know if any existing health or disability insurance is to be replaced with the purchase of this long-term care insurance policy, and MUST be answered in all cases. If the question is answered "yes," then both the Applicant(s) and the producer must sign two copies of the Notice to Applicant Regarding Replacement of Accident and Sickness or Long-Term Care Insurance. One copy, designated by "APPC" in the form number in the lower left of the form, is to be retained by the Applicant(s). The second copy, designated by "COC" in the form number, is to be returned with the application.

Question 4 – The type of dwelling that the person resides in is part of the field underwriting requirements and is used by the LTC Underwriting department in the underwriting process.

Application – The producer certifies that the application question answers provided by the Applicant(s) are recorded in the application; the answers as recorded are complete and true; the Applicant(s) understand(s) that the answers to the questions will be relied on to underwrite the coverage being applied for; and the Applicant(s) realize(s) that false information could cause the policy to be rescinded or an otherwise valid claim be denied.

Conditional Receipt – The producer, if cash is collected, is certifying that a conditional receipt was given to the Applicant(s) and the Applicant(s) understand(s) that no coverage will be effective until the application is approved.

Underwriting – The producer states that he/she has explained that a personal interview may be conducted during the underwriting of the application; medical records will be ordered for the prescribing physicians listed in the application; and the policy benefits being applied for in the application.

Replacement – The producer states that if there is any reason to believe that a replacement will occur as a result of the issuance of the coverage applied for in the application, then a Replacement Notice was signed by both the producer and the Applicant(s) with one copy being retained by the Applicant(s) and the other being returned to New York Life with the application.

Signature Witness – If the producer witnesses the Applicant(s') signature(s) in the application, then the field underwriting requirements in the Agent's Underwriting Guide are assumed to be followed. However, if the producer does not physically witness the Applicant(s') signing the application, a face-to-face assessment to verify functional and cognitive capacity will be ordered. The producer will be liable for paying for the face-to-face assessment.

Producer's Report – Information about the Applicant(s)/sale(s) are to be completed on this form as well as producer information. Only the writing producer needs to sign the form.

Applicant(s)/Sale(s) Information – Complete all questions and fill in all blanks to provide information for processing the application. The first section of this form is considered part of field underwriting and requires the producer to confirm that he conducted a personal interview, assess the Applicant(s) surroundings, financial circumstances and mental capabilities and alertness. The second half of this section provides a space to indicate the risk class quoted, the premium quoted and confirms whether or not a conditional receipt was provided (if provided, implies cash was received with the application).

Producer Information – The information provided in this area is to establish the producer personal information as well as determine when correspondence is to be sent, how to split commissions if appropriate, and producer licensing information. Proper licensing, appointment and continuing education course completion is essential for the application to be processed. If the producer is not properly licensed and appointed by New York Life and has the required continuing education, the application will be returned to the producer.

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APPLICATION
Long-Term Care Insurance or Nursing Facility and Residential Care Facility Only Insurance

NEW YORK LIFE INSURANCE COMPANY
51 Madison Avenue, New York, NY 10010

To be completed and returned

PART I – APPLICANT INFORMATION

Complete the following information.

Full Name: First Middle Last		Social Security Number: – –
Street Address:		Date of Birth: Month ▼ Day ▼ Year
City State ▼ Zip		Sex: ❑ Female ❑ Male
Daytime Telephone Number: ( ) –	Best time to call ❑ Morning ❑ Afternoon ❑ Evening	Marital Status: ❑ Married ❑ Single ❑ Widowed ❑ Divorced
Email Address:		With whom do you live? ❑ Spouse ❑ Relative ❑ Other ❑ No one
State the name of the Multi-Life Program sponsoring organization and location/department, if applicable. _____		

PART II – SPOUSE INFORMATION

Complete the following information only if the Applicant's Spouse is also applying for coverage on this Application

Full Name: First Middle Last		Social Security Number: – –
Street Address:		Date of Birth: Month ▼ Day ▼ Year
City State ▼ Zip		Sex: ❑ Female ❑ Male
Daytime Telephone Number: ( ) –	Best time to call ❑ Morning ❑ Afternoon ❑ Evening	Marital Status: ❑ Married ❑ Single ❑ Widowed ❑ Divorced
Email Address:		With whom do you live? ❑ Spouse ❑ Relative ❑ Other ❑ No one

PART III – POLICYOWNER INFORMATION

Complete the following information only if the Applicant is not the Policyowner.

Full Name: First Middle Last DO NOT COMPLETE		Social Security Number: – –
Street Address:		Telephone Number: ( ) –
City State Zip		Email Address:

APPLICATION
Long-Term Care Insurance or Nursing Facility and Residential Care Facility Only Insurance

NEW YORK LIFE INSURANCE COMPANY
51 Madison Avenue, New York, NY 10010

To be completed and returned

PART IV – PLAN SELECTION

You must select one and only one feature/benefit in each category.

	Applicant	Spouse
Nursing Facility Maximum Daily Benefit (NFMDB) (Also the Residential Care Facility MDB)	$_____ ($100-$400)	$_____ ($100-$400)
Policy Lifetime Maximum Benefit (NFMDB x multiplier)	❑ 2 Years (730 x NFMDB) $_____ ❑ 3 Years (1095 x NFMDB) $_____ ❑ 4 Years (1460 x NFMDB) $_____ ❑ 5 Years (1825 x NFMDB) $_____ ❑ 7 Years (2555 x NFMDB) $_____ ❑ 10 Years (3650 x NFMDB) $_____ ❑ Unlimited Unlimited	❑ 2 Years (730 x NFMDB) $_____ ❑ 3 Years (1095 x NFMDB) $_____ ❑ 4 Years (1460 x NFMDB) $_____ ❑ 5 Years (1825 x NFMDB) $_____ ❑ 7 Years (2555 x NFMDB) $_____ ❑ 10 Years (3650 x NFMDB) $_____ ❑ Unlimited Unlimited
Home and Community-Based Care Maximum Daily Benefit	❑ Nursing Facility and Residential Care Facility Only ❑ 50% of your NFMDB ❑ 60% of your NFMDB ❑ 70% of your NFMDB ❑ 80% of your NFMDB ❑ 90% of your NFMDB ❑ 100% of your NFMDB	❑ Nursing Facility and Residential Care Facility Only ❑ 50% of your NFMDB ❑ 60% of your NFMDB ❑ 70% of your NFMDB ❑ 80% of your NFMDB ❑ 90% of your NFMDB ❑ 100% of your NFMDB
Elimination Period	❑ 20 days ❑ 90 days ❑ 180 days ❑ 365 days	❑ 20 days ❑ 90 days ❑ 180 days ❑ 365 days
Inflation Protection Type (You must positively reject the 5% Compound Increase in Part XII of this Application before You are eligible to select None, Simple or the CPI-U options.)	❑ None ❑ 5% Compound Increase for Life ❑ 3% Compound Increase for Life ❑ _% Simple Increase for Life (3% to 6%) CPI-U Benefit Increase Offer ❑ CPI-U Automatic Benefit Increase for Life ❑ CPI-U	❑ None ❑ 5% Compound Increase for Life ❑ 3% Compound Increase for Life ❑ _% Simple Increase for Life (3% to 6%) CPI-U Benefit Increase Offer ❑ CPI-U Automatic Benefit Increase for Life ❑ CPI-U
Optional Riders (More than one option may be selected)	❑ Couples Additional Benefit ❑ Shared Care Benefit ❑ Return of Premium Upon Death Benefit ❑ Nonforfeiture Benefit	❑ Couples Additional Benefit ❑ Shared Care Benefit ❑ Return of Premium Upon Death Benefit ❑ Nonforfeiture Benefit

APPLICATION
Long-Term Care Insurance or Nursing Facility and Residential Care Facility Only Insurance

NEW YORK LIFE INSURANCE COMPANY
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PART IV – PLAN SELECTION (CONTINUED)

	Applicant	Spouse
Are you requesting an effective date other than the application date? (If yes, specify date.)	❑ Yes ❑ No Date _____	❑ Yes ❑ No Date _____

Your Policy's Effective Date and coverage will begin on the date you sign this application, if you are making payment with this application and you are approved for coverage regardless of any change in your health status. Your Policy's Effective Date will be the date we approve your application if you are not making a payment with this application or the date you request above that is later than the application date. You will be covered on that Policy Effective Date provided we deliver your Policy, you pay the first premium in full, and you remain in good health (as we determine) until your Policy is delivered.

PART V – ELIGIBILITY QUESTIONS

	Applicant	Spouse
1. Do You currently need human assistance or supervision to perform any of the following activities:		
a. Bathing?	❑ Yes ❑ No	❑ Yes ❑ No
b. Dressing?	❑ Yes ❑ No	❑ Yes ❑ No
c. Eating?	❑ Yes ❑ No	❑ Yes ❑ No
d. Toileting?	❑ Yes ❑ No	❑ Yes ❑ No
e. Bowel?	❑ Yes ❑ No	❑ Yes ❑ No
f. Bladder control?	❑ Yes ❑ No	❑ Yes ❑ No
g. Moving in/out of a bed?	❑ Yes ❑ No	❑ Yes ❑ No
h. Moving in/out of a chair?	❑ Yes ❑ No	❑ Yes ❑ No
2. Do You use any of the following:		
a. Walker?	❑ Yes ❑ No	❑ Yes ❑ No
b. Wheelchair?	❑ Yes ❑ No	❑ Yes ❑ No
c. Oxygen?	❑ Yes ❑ No	❑ Yes ❑ No
d. Dialysis?	❑ Yes ❑ No	❑ Yes ❑ No
e. Respirator?	❑ Yes ❑ No	❑ Yes ❑ No
f. Quad cane (4-pronged cane)?	❑ Yes ❑ No	❑ Yes ❑ No
g. Motorized cart?	❑ Yes ❑ No	❑ Yes ❑ No
3. Have You ever been diagnosed or treated for any of the following medical conditions:		
a. Alzheimer's Disease?	❑ Yes ❑ No	❑ Yes ❑ No
b. Chronic Memory Loss?	❑ Yes ❑ No	❑ Yes ❑ No
c. Senility or Dementia?	❑ Yes ❑ No	❑ Yes ❑ No

To be completed and returned

PART V – ELIGIBILITY QUESTIONS (CONTINUED)

	Applicant	Spouse
d. Lou Gehrig's Disease (ALS)?	❑ Yes ❑ No	❑ Yes ❑ No
e. Huntington's Disease	❑ Yes ❑ No	❑ Yes ❑ No
f. Multiple Sclerosis?	❑ Yes ❑ No	❑ Yes ❑ No
g. Parkinson's Disease?	❑ Yes ❑ No	❑ Yes ❑ No
h. Muscular Dystrophy?	❑ Yes ❑ No	❑ Yes ❑ No
i. Cerebral Palsy?	❑ Yes ❑ No	❑ Yes ❑ No
j. Spina Bifida?	❑ Yes ❑ No	❑ Yes ❑ No
k. Multiple Episodes of Strokes?	❑ Yes ❑ No	❑ Yes ❑ No
l. Multiple Transient Ischemic Attacks (TIA)?	❑ Yes ❑ No	❑ Yes ❑ No
m. Cirrhosis of the Liver?	❑ Yes ❑ No	❑ Yes ❑ No
n. Systemic Lupus?	❑ Yes ❑ No	❑ Yes ❑ No
o. Polycystic Kidney Disease?	❑ Yes ❑ No	❑ Yes ❑ No
p. Acquired Immune Deficiency Syndrome (AIDS)?	❑ Yes ❑ No	❑ Yes ❑ No
q. AIDS-Related Complex (ARC)?	❑ Yes ❑ No	❑ Yes ❑ No
4. Within the past two (2) years, have You used insulin to control diabetes?	❑ Yes ❑ No	❑ Yes ❑ No
5. Have You had any of the following within the past 6 months:		
a. Heart Surgery?	❑ Yes ❑ No	❑ Yes ❑ No
b. Back Surgery?	❑ Yes ❑ No	❑ Yes ❑ No
c. Spine Surgery?	❑ Yes ❑ No	❑ Yes ❑ No
6. Have You had a Heart Attack within the past six (6) months?	❑ Yes ❑ No	❑ Yes ❑ No
7. Have You had any of the following within the past twenty-four (24) months:		
a. Transient Ischemic Attack (TIA)?	❑ Yes ❑ No	❑ Yes ❑ No
b. Stroke?	❑ Yes ❑ No	❑ Yes ❑ No
c. Mini Stroke?	❑ Yes ❑ No	❑ Yes ❑ No

"Yes" answers to any part of questions 1 through 7 of Part V will disqualify that person for coverage.

APPLICATION
Long-Term Care Insurance or Nursing Facility and Residential Care Facility Only Insurance

NEW YORK LIFE INSURANCE COMPANY
51 Madison Avenue, New York, NY 10010

To be completed and returned

PART VI – HEALTH STATEMENT

	Applicant	Spouse
1. Have You had or been recommended for any of the following:		
a. Home care?	❑ Yes ❑ No	❑ Yes ❑ No
b. Adult day care?	❑ Yes ❑ No	❑ Yes ❑ No
c. Care in a Nursing Facility?	❑ Yes ❑ No	❑ Yes ❑ No
d. Care in a Residential Care Facility for the Elderly?	❑ Yes ❑ No	❑ Yes ❑ No
2. Within the past five (5) years have you consulted with a health care professional, been diagnosed, received treatment, taken medication or been confined to a hospital, nursing care facility or other institution for any of the following: (Check each condition that applies.)		
a. Heart attack?	❑ Yes ❑ No	❑ Yes ❑ No
b. Heart Failure?	❑ Yes ❑ No	❑ Yes ❑ No
c. Heart Surgery?	❑ Yes ❑ No	❑ Yes ❑ No
d. Angioplasty?	❑ Yes ❑ No	❑ Yes ❑ No
e. Chest pain?	❑ Yes ❑ No	❑ Yes ❑ No
f. Irregular heart beat?	❑ Yes ❑ No	❑ Yes ❑ No
g. Other heart condition?	❑ Yes ❑ No	❑ Yes ❑ No
h. Stroke?	❑ Yes ❑ No	❑ Yes ❑ No
i. Carotid artery stenosis?	❑ Yes ❑ No	❑ Yes ❑ No
j. Cancer?	❑ Yes ❑ No	❑ Yes ❑ No
k. Tumor?	❑ Yes ❑ No	❑ Yes ❑ No
l. Hodgkin's Disease?	❑ Yes ❑ No	❑ Yes ❑ No
m. Malignant lymphoma?	❑ Yes ❑ No	❑ Yes ❑ No
n. Growths?	❑ Yes ❑ No	❑ Yes ❑ No
o. Leukemia?	❑ Yes ❑ No	❑ Yes ❑ No
p. Diabetes?	❑ Yes ❑ No	❑ Yes ❑ No
q. Mental, emotional or nervous disorder?	❑ Yes ❑ No	❑ Yes ❑ No
r. Depression?	❑ Yes ❑ No	❑ Yes ❑ No
s. Confusion?	❑ Yes ❑ No	❑ Yes ❑ No
t. Anxiety?	❑ Yes ❑ No	❑ Yes ❑ No
u. Alcoholism?	❑ Yes ❑ No	❑ Yes ❑ No
v. Drug addiction?	❑ Yes ❑ No	❑ Yes ❑ No
w. Fainting spells?	❑ Yes ❑ No	❑ Yes ❑ No
x. Blacking out?	❑ Yes ❑ No	❑ Yes ❑ No
y. Epilepsy?	❑ Yes ❑ No	❑ Yes ❑ No
z. Seizures?	❑ Yes ❑ No	❑ Yes ❑ No
aa. Convulsions?	❑ Yes ❑ No	❑ Yes ❑ No
bb. Other neurological disorder?	❑ Yes ❑ No	❑ Yes ❑ No
cc. Emphysema?	❑ Yes ❑ No	❑ Yes ❑ No
dd. Asthma	❑ Yes ❑ No	❑ Yes ❑ No
ee. Chronic obstructive pulmonary disease?	❑ Yes ❑ No	❑ Yes ❑ No
ff. Other lung problems or breathing conditions?	❑ Yes ❑ No	❑ Yes ❑ No
gg. Arthritis?	❑ Yes ❑ No	❑ Yes ❑ No
hh. Fibromyalgia?	❑ Yes ❑ No	❑ Yes ❑ No

To be completed and returned

PART VI – HEALTH STATEMENT (CONTINUED)

	Applicant	Spouse
ii. Osteoporosis?	❑ Yes ❑ No	❑ Yes ❑ No
jj. Pain in the muscles or joints?	❑ Yes ❑ No	❑ Yes ❑ No
kk. Disorders of the bones?	❑ Yes ❑ No	❑ Yes ❑ No
ll. Joints or spine fracture?	❑ Yes ❑ No	❑ Yes ❑ No
mm. Hip, knee or other joint replacement?	❑ Yes ❑ No	❑ Yes ❑ No
nn. Scleroderma?	❑ Yes ❑ No	❑ Yes ❑ No
oo. Myasthenia gravis?	❑ Yes ❑ No	❑ Yes ❑ No
pp. Paralysis?	❑ Yes ❑ No	❑ Yes ❑ No
qq. Numbness?	❑ Yes ❑ No	❑ Yes ❑ No
rr. Visual disturbances?	❑ Yes ❑ No	❑ Yes ❑ No
ss. Balance problems or falls?	❑ Yes ❑ No	❑ Yes ❑ No
tt. Tremors?	❑ Yes ❑ No	❑ Yes ❑ No
uu. Skin ulcers?	❑ Yes ❑ No	❑ Yes ❑ No
vv. Chronic Fatigue Syndrome?	❑ Yes ❑ No	❑ Yes ❑ No
3. Within the past five (5) years have You had or been advised to have:		
a. Surgery?	❑ Yes ❑ No	❑ Yes ❑ No
b. Hospitalization?	❑ Yes ❑ No	❑ Yes ❑ No
c. Diagnostic testing such as:		
i. Laboratory testing?	❑ Yes ❑ No	❑ Yes ❑ No
ii. Blood chemistry or testing?	❑ Yes ❑ No	❑ Yes ❑ No
iii. Urine test or urinalysis?	❑ Yes ❑ No	❑ Yes ❑ No
iv. Biopsy or culture testing?	❑ Yes ❑ No	❑ Yes ❑ No
Other tests such as:		
i. X-ray?	❑ Yes ❑ No	❑ Yes ❑ No
ii. Ultrasound or Doppler studies?	❑ Yes ❑ No	❑ Yes ❑ No
iii. EKG, CT, MRI or MRA scans?	❑ Yes ❑ No	❑ Yes ❑ No
iv. EMG or EEG?	❑ Yes ❑ No	❑ Yes ❑ No
v. Angiography, cardiac stress testing or echocardiogram?	❑ Yes ❑ No	❑ Yes ❑ No
vi. Endoscopy or colonoscopy?	❑ Yes ❑ No	❑ Yes ❑ No
e. Memory Testing?	❑ Yes ❑ No	❑ Yes ❑ No
4. Are You missing any part of Your fingers, hands, feet or limbs due to:		
a. Amputation?	❑ Yes ❑ No	❑ Yes ❑ No
b. Accident?	❑ Yes ❑ No	❑ Yes ❑ No
c. Disease?	❑ Yes ❑ No	❑ Yes ❑ No
d. Deformity?	❑ Yes ❑ No	❑ Yes ❑ No
5. Do You have any conditions causing:		
a. Crippling?	❑ Yes ❑ No	❑ Yes ❑ No
b. Limited motion?	❑ Yes ❑ No	❑ Yes ❑ No
6. Do you use any supportive equipment such as a brace, back support, or splint?	❑ Yes ❑ No	❑ Yes ❑ No
7. Within the past five (5) years have you had a routine medical examination for any reason not previously stated?	❑ Yes ❑ No	❑ Yes ❑ No
8. Within the past five (5) years have you consulted with a physician or health care professional for any reason not previously stated?	❑ Yes ❑ No	❑ Yes ❑ No

APPLICATION
Long-Term Care Insurance or Nursing Facility and Residential Care Facility Only Insurance

NEW YORK LIFE INSURANCE COMPANY
51 Madison Avenue, New York, NY 10010

To be completed and returned

PART VI – HEALTH STATEMENT (CONTINUED)

In the space below, provide details for all "YES" answers in Part VI – Health Statement questions 1 through 8 above. Attach additional sheet if necessary. If attaching additional sheet please include applicant's full signature and date.

Question No.	Date of Onset	Condition & Details (e.g., Diagnosis, Reason for Tests, Treatment/Results, Operations, Date Recovered, Current Status)	Name & Address of Each Physician, Practitioner, Hospital
Question No.____ ❑ Applicant ❑ Spouse			
Question No.____ ❑ Applicant ❑ Spouse			
Question No.____ ❑ Applicant ❑ Spouse			
Question No.____ ❑ Applicant ❑ Spouse			
Question No.____ ❑ Applicant ❑ Spouse			
Question No.____ ❑ Applicant ❑ Spouse			
Question No.____ ❑ Applicant ❑ Spouse			
Question No.____ ❑ Applicant ❑ Spouse			

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PART VII (A) – PHYSICIAN AND MEDICATION INFORMATION

Are you taking any prescription medications or has any medication been prescribed for you within the past 6 months?	Applicant	Spouse
	❑ Yes ❑ No	❑ Yes ❑ No

PART VII (B) – PHYSICIAN AND MEDICATION INFORMATION

If answered "Yes" to the above question - PART VII (A) please complete the following. Attach additional sheet if necessary. If attaching additional sheet please include applicant's full signature and date.

Applicant / Spouse	Date Taken	List Prescription Medication with Dosage	Diagnosis	Prescribing Physician Name, Address and Telephone
❑ Applicant ❑ Spouse				
❑ Applicant ❑ Spouse				
❑ Applicant ❑ Spouse				
❑ Applicant ❑ Spouse				
❑ Applicant ❑ Spouse				
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❑ Applicant ❑ Spouse				

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PART VIII – UNDERWRITING INFORMATION

	Applicant	Spouse
1. What is your height?	___ft. ___in.	___ft. ___in.
2. What is your weight?	_____lbs.	_____lbs.
3. a. Do you currently smoke?	❑ Yes ❑ No	❑ Yes ❑ No
If yes, how long have you smoked?		
If yes, how much per day?		
b. Have you ever smoked?	❑ Yes ❑ No	❑ Yes ❑ No
If yes, when did you quit?		
4. Within the past five (5) years, have you received disability or workers' compensation payments?	❑ Yes ❑ No	❑ Yes ❑ No
If yes, provide dates and brief details. _____ _____		
5. Have You ever been declined for long-term care insurance?	❑ Yes ❑ No	❑ Yes ❑ No
If "Yes", what was the name of the insurance company?		
6. Are You currently employed outside the home?	❑ Yes ❑ No	❑ Yes ❑ No
Number of Hours Worked per Week	___ hrs/week	___ hrs/week
Name of Employer		

7. Do you do any of the following? *(On the blank lines please explain how often)*

Activity	Applicant	Spouse
Exercise	❑ Yes _____ ❑ No	❑ Yes _____ ❑ No
Drive a vehicle	❑ Yes _____ ❑ No	❑ Yes _____ ❑ No
Do volunteer work	❑ Yes _____ ❑ No	❑ Yes _____ ❑ No

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PART IX – OTHER INSURANCE INFORMATION

	Applicant	Spouse
1. Do You have another long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?	❑ Yes ❑ No	❑ Yes ❑ No
If "Yes", with which company?		
2. Did you have another long-term care insurance policy or certificate in force during the last twelve (12) months?	❑ Yes ❑ No	❑ Yes ❑ No
a. If "Yes," with which company?		
b. If that policy lapsed, when did it lapse?		
3. Are you covered by Medicaid?	❑ Yes ❑ No	❑ Yes ❑ No
4. Do you intend to replace any of your medical or health insurance coverage with this policy?	❑ Yes ❑ No	❑ Yes ❑ No

PART X – PROTECTION AGAINST UNINTENDED LAPSE

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care or nursing facility and residential care only insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid.

Please fill in the full name and complete home address of the person you wish to designate below. If you elect not to designate another person, please indicate that below. **Your designation or waiver of right to designate another person is confirmed by your signature in Part XI – Acknowledgements of this application.**

Applicant

❑ I designate the following person:

_____
Name (Please Print)

_____
Address (Please Print)

_____
City State Zip

❑ I elect NOT to designate any person to receive such notice.

Spouse

❑ I designate the following person:

_____
Name (Please Print)

_____
Address (Please Print)

_____
City State Zip

❑ I elect NOT to designate any person to receive such notice.

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PART XI – ACKNOWLEDGEMENTS

I (We) the undersigned Applicant (Spouse) certify that I (We) have read or had read to Me (Us), the completed Application. The answers given are complete and true to the best of my (Our) knowledge and belief. I (We) understand that the New York Life Insurance Company will rely on the written answers to the questions in this Application. I (We) realize that any false statement or misrepresentation in this Application may result in loss of coverage under the Policy or an otherwise valid claim to be denied.

I (We) agree that New York Life or its representative may conduct a personal interview as part of the underwriting process. If I (We) have made payment with this Application, I (We) agree to the terms of the Conditional Receipt that has been given to me (Us) and understand that no coverage will be in effect until this Application has been approved. I (We) understand that the agent cannot determine eligibility for or alter the terms of the proposed policy.

CAUTION: If your answers on this Application are misstated or untrue, New York Life Insurance Company may have the right to deny benefits or rescind your Policy, subject to the provisions of the Policy.

1

This application signed at _____, _____
City State

Date	Applicant's Name (Please Print)	X **Signature of Applicant**
Date	Spouse's Name (Please Print)	X **Signature of Spouse**
Date	DO NOT COMPLETE Policyowner's Name, if other than Applicant (Please Print)	X **Signature of Policyowner**

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PART XII – CHECKLIST

The Applicant(s) must check the appropriate Yes or No box and the Applicant(s) and the producer must sign below to indicate that the Applicant(s) have received a copy of the following documents:

	Applicant	Spouse
1. I have received the Consumer's Guide to Long-Term Care Insurance, "Taking Care of Tomorrow."	❑ Yes ❑ No	❑ Yes ❑ No
2. I am eligible for Medicare.	❑ Yes ❑ No	❑ Yes ❑ No
3. I have received the "Guide to Health Insurance for People with Medicare."	❑ Yes ❑ No	❑ Yes ❑ No
4. I have received the Outline of Coverage and the graphs that compare the benefits and premiums of the Policy with and without inflation protection and I reject the Compound Inflation Protection. Specifically, I have reviewed the Comprehensive Long-Term Care or the Nursing Facility and Residential Care Facility Only Insurance Policy for which I am applying and I reject the 5% Compound Inflation Protection.	❑ Yes ❑ No	❑ Yes ❑ No
5. I have received information regarding the Health Insurance Counseling and Advocacy program (HICAP), administered by the California Department of Aging, that provides counseling to California senior citizens and is found on the last page of the Outline of Coverage.	❑ Yes ❑ No	❑ Yes ❑ No
6. I have reviewed and completed the "Long-Term Care Insurance Personal Worksheet." I understand that the information I have provided will be used by New York Life's Underwriting Department to verify the suitability of the Long-Term Care Insurance policy that I have selected in my application. If I elect not to complete the financial information, New York Life will pend the underwriting of my application and send me a Suitability Letter advising me that without the financial information the suitability of the purchase cannot be determined.	❑ Yes ❑ No	❑ Yes ❑ No
7. I have received a copy of "Things You Should Know Before You Buy Long-Term Care Insurance."	❑ Yes ❑ No	❑ Yes ❑ No
8. I have received a copy of the "Long-Term Care Insurance Potential Rate Increase Disclosure Form."	❑ Yes ❑ No	❑ Yes ❑ No
9. If the Policy applied for is to replace an existing policy, I have signed two copies of the "Notice to Applicant Regarding Replacement of Accident and Sickness or Long-Term Care Insurance." I have retained one copy and the agent will send the second copy to New York Life with my application.	❑ Yes ❑ No	❑ Yes ❑ No

2

_____ Date X _____ **Signature of Applicant** _____ Date X _____ **Signature of Spouse**

_____ Date X _____ **Signature of Producer**

APPLICATION
Long-Term Care Insurance or Nursing Facility and Residential Care Facility Only Insurance

NEW YORK LIFE INSURANCE COMPANY
51 Madison Avenue, New York, NY 10010

To be completed and returned

PART XIII – PAYMENT MODE AND AUTHORIZATION FOR ELECTRONIC FUND TRANSFER

Is payment being made with this Application? ❑ Yes ❑ No

If yes, what is the amount of payment? $ _____
(In California, We cannot request more than one-month premium.)

I (we) wish to pay premiums as follows:

DIRECT BILL	AUTOMATIC PAYMENT OPTIONS	PAYROLL DEDUCTION *(For New York Life Approved Employers only)*
❑ Annually	❑ Monthly Electronic Fund Transfer (EFT)*	❑ Monthly
	❑ Monthly "MainStay" Withdrawal	
	❑ NYL Annuity Frequency: _____	
❑ Semi-Annually	❑ NYL Producer Ledger Deduction	❑ Semi-Monthly (twice/month)
❑ Quarterly	Frequency: _____ Producer ID#: _____	❑ Bi-Weekly (every other week)
	❑ NYLIFE Securities Brokerage Account	❑ Weekly
	Account #: _____ ABA #: _____	

Billing address:

_____

Street Address City State Zip

*AUTOMATIC PAYMENT OPTION AUTHORIZATION

If you checked Monthly Electronic Fund Transfer (EFT) and if you submitted a premium payment by check with this Application, New York Life will use the information on your check for your EFT withdrawal. If you did not submit a payment by check with this Application and you checked EFT above, please provide a voided check with this Application.

By checking Automatic Payment Options or Payroll Deduction, and signing this Application, I (we) request and authorize New York Life Insurance Company to make monthly withdrawals against the account specified or any account subsequently named by me (us), and such bank, employer or financial institution to process these withdrawals as if I (we) had signed them, for the purpose of collecting the premiums for any Policy (ies) issued as a result of this Application.

3

_____ X _____ _____ X _____
Date **Signature of Applicant** Date **Signature of Spouse**

SIGN Applicant Return

LONG-TERM CARE INSURANCE MEDICAL AUTHORIZATION
APPLICANT

NEW YORK LIFE INSURANCE COMPANY
51 Madison Avenue, New York, NY 10010

To be completed and returned (One form for each Applicant)

I hereby authorize any physician; health care professional; hospital; clinic; laboratory; pharmacy; medical or medically related facility; alcohol or drug facility; pharmacy or pharmacy benefit manager; other health care provider; any consumer reporting agency such as the Medical Information Bureau, Inc. (MIB); insurance company; or any other organization, institution or person that has provided payment, treatment or services to me within the past five years to disclose my medical records (electronic or paper form) covering such payment, treatment or services to New York Life Insurance Company (New York Life) to see if (and on what basis) I qualify for the insurance applied for. This includes, but is not limited to, data, reports, and records that contain history, findings, diagnosis, prognosis and treatment(s) about my physical and mental health, sexually transmitted diseases (but excludes HIV/AIDS/ARC), and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes. This also includes any portion of my medical records during this period I have previously requested be withheld from release, which request I hereby terminate for the sole purpose of the insurance for which I am applying in this application. I authorize New York Life to make a brief report of my protected health information to MIB.

I understand that this authorization must be fully completed and signed as a condition of applying for insurance with New York Life. My current application will not be accepted unless this authorization is signed.

I understand that my authorized representative or I will receive a copy of this signed authorization. A copy of this authorization shall act as the original.

This authorization is valid for two years from the date shown below unless revoked by me in writing. I have the right to revoke this authorization at any time by notifying New York Life in writing at the address on this authorization. My revocation will not be effective to the extent New York Life or any other person already has disclosed, collected information, or taken other action in reliance on it. My revocation will also not be effective to the extent state law gives New York Life the right to contest a claim under the policy or the policy itself.

The information New York Life obtains based on this authorization may be subject to further disclosure. For example, New York Life may be required to provide it to an insurance regulatory or other government agency. In this case, the information may no longer be protected by the rules governing this authorization.

Applicant

Name: First Middle Last (Please Print) Date of Birth

Maiden Name (if applicable)

Address

City State Zip

4

Date

X **Signature of Applicant**

LONG-TERM CARE INSURANCE MEDICAL AUTHORIZATION
SPOUSE

NEW YORK LIFE INSURANCE COMPANY
51 Madison Avenue, New York, NY 10010

To be completed and returned (One form for each Applicant)

I hereby authorize any physician; health care professional; hospital; clinic; laboratory; pharmacy; medical or medically related facility; alcohol or drug facility; pharmacy or pharmacy benefit manager; other health care provider; any consumer reporting agency such as the Medical Information Bureau, Inc. (MIB); insurance company; or any other organization, institution or person that has provided payment, treatment or services to me within the past five years to disclose my medical records (electronic or paper form) covering such payment, treatment or services to New York Life Insurance Company (New York Life) to see if (and on what basis) I qualify for the insurance applied for. This includes, but is not limited to, data, reports, and records that contain history, findings, diagnosis, prognosis and treatment(s) about my physical and mental health, sexually transmitted diseases (but excludes HIV/AIDS/ARC), and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes. This also includes any portion of my medical records during this period I have previously requested be withheld from release, which request I hereby terminate for the sole purpose of the insurance for which I am applying in this application. I authorize New York Life to make a brief report of my protected health information to MIB.

I understand that this authorization must be fully completed and signed as a condition of applying for insurance with New York Life. My current application will not be accepted unless this authorization is signed.

I understand that my authorized representative or I will receive a copy of this signed authorization. A copy of this authorization shall act as the original.

This authorization is valid for two years from the date shown below unless revoked by me in writing. I have the right to revoke this authorization at any time by notifying New York Life in writing at the address on this authorization. My revocation will not be effective to the extent New York Life or any other person already has disclosed, collected information, or taken other action in reliance on it. My revocation will also not be effective to the extent state law gives New York Life the right to contest a claim under the policy or the policy itself.

The information New York Life obtains based on this authorization may be subject to further disclosure. For example, New York Life may be required to provide it to an insurance regulatory or other government agency. In this case, the information may no longer be protected by the rules governing this authorization.

Spouse

Name: First Middle Last (Please Print) Date of Birth

Maiden Name (if applicable)

Address

City State Zip

4

Date

X **Signature of Spouse**

SIGN Applicant Return

LONG-TERM CARE INSURANCE PERSONAL WORKSHEET

NEW YORK LIFE INSURANCE COMPANY
51 Madison Avenue, New York, NY 10010

To be completed by the APPLICANT(s) and returned

People buy Long-Term Care Insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care, or don't want to go on Medicaid. But, long-term care insurance may be expensive, and may not be right for everyone.

By state law, New York Life Insurance Company must fill out part of the information on this worksheet and ask you to fill out the rest to help you and New York Life decide if you should buy this policy.

PREMIUM INFORMATION. Policy form series ILTC-5000, INH-5000, ILTC-4300, INH-4300, NQ-ILTC-4400 and NQ-INH-4400

The premium for the coverage you are considering will be:	Applicant	$ _____ Per ❑ month or ❑ year
	Spouse	$ _____ Per ❑ month or ❑ year

TYPE OF POLICY: Guaranteed Renewable

NEW YORK LIFE'S RIGHT TO INCREASE PREMIUMS:
New York Life has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.

RATE INCREASE HISTORY:
New York Life has sold long-term care insurance since 1988 and has sold this policy since 2014 (a similar version was sold from 2004 until release of the new series in 2014). The company has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increases.

Policy Form Series - Not every policy form series was available in every state	**Years available for Sale**	**Rate Increase Approved in these States**	**Rate Increase Requested/ Pending Approval in these States**	**Percentage of Increase Requested**	**Effective Year(s) of Increase: Percentage of Increase Implemented**
ILTC-4300, INH-4300, 21156, 21157	1998-2002	AK, AL[1], AZ, CO, HI, IA[1], IL, KS, KY, LA, ME[1], MI, MN, MO, NC, NE[1], NJ[1], OH, OR, SD, TN[1], TX, UT, VA[1], WA, WI, WV, WY	CAP, CT, MA, RI, VT	0-40%	2014: 0-40%
		NH[1]		0-40%	2014: 30%
		ID		0-40%	2014: 0-25.1%
		DE, FL, MS, MT, OK		0-40%	2014: 0-25%
		AR, PA, SC, CA		0-40%	2014: 0-20%
		NV		0-40%	2014: 0-16.9%
		NY		0-40%	2014: 0-16%
		GA, ND, NM		0-40%	2014: 0-15%
		MD		0-40%	2014: 15%
		IN		0-40%	2014: 0-11.5%
		DC		0-40%	2014: 0-10%

[1] The increase will be phased in over either a two or three year period.

LONG-TERM CARE INSURANCE PERSONAL WORKSHEET

NEW YORK LIFE INSURANCE COMPANY
51 Madison Avenue, New York, NY 10010

To be completed by the APPLICANT(s) and returned

Policy Form Series - Not every policy form series was available in every state	**Years available for Sale**	**Rate Increase Approved in these States**	**Rate Increase Requested/ Pending Approval in these States**	**Percentage of Increase Requested**	**Effective Year(s) of Increase: Percentage of Increase Implemented**
ILTC-5000, INH-5000, FLTC-5000, FNH-5000, 21156, 21157, 20150, 21050 50DDAP, 21050 50TAP, 21050 100 DDAP, 21050 100TAP	2002-present	AK, AL[1], AZ, CO, IA[1], IL, KS, KY, LA, ME[1], MI, MN, MO, NC, NE[1], OH, OR, SD, TN[1], TX, UT, WA, WI, WV, WY	CAP, CT, MA, RI, VT	0-40%	2014: 0-40%
		VA[1]		0-40%	2015: 0-35%
		NH[1]		0-40%	2014: 25.1-30%
		ID		0-40%	2014: 0-25.1%
		DE, FL, MS, OK		0-40%	2014: 0-25%
		HI, PA, SC, CA		0-40%	2014: 0-20%
		GA, MT, ND, NJ, NM, NY		0-40%	2014: 0-15%
		MD		0-40%	2014: 15%
		IN		0-40%	2014: 0-11.5%
		NV		0-40%	2014: 0-11.3%
		DC, NY P'ship		0-40%	2014: 0-10%
		AR		0-40%	2014: 0-5%

[1] The increase will be phased in over either a two or three year period.

A rate guide is available that compares the policies sold by different insurers, the benefits provided in those policies, and sample premiums. The rate guide also provides a history of the rate increases, if any, for the policies issued by different insurers in each state in which they do business, since January 1, 1990. You can obtain a copy of this rate guide by calling the Department of Insurance's consumer toll-free telephone number (1-800-927-HELP), by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free telephone number (1-800-434-0222), or by accessing the Department of Insurance's Internet web site (www.insurance.ca.gov).

LONG-TERM CARE INSURANCE PERSONAL WORKSHEET

NEW YORK LIFE INSURANCE COMPANY
51 Madison Avenue, New York, NY 10010

To be completed by the APPLICANT(s) and returned

QUESTIONS RELATED TO YOUR INCOME

How will you pay each year's premiums?	❑ From my (our) Income ❑ From my (our) Savings/Investments ❑ My (our) Family will Pay
Have you considered whether you could afford to keep the policy if the premiums went up, for example, by 20%?	❑ Yes ❑ No
What is your annual income? (check one)	**Applicant** / **Spouse** ❑ Under $10,000 / ❑ Under $10,000 ❑ $10,000-$20,000 / ❑ $10,000-$20,000 ❑ $20,000-$30,000 / ❑ $20,000-$30,000 ❑ $30,000-$50,000 / ❑ $30,000-$50,000 ❑ Over $50,000 / ❑ Over $50,000
How do you expect your income to change over the next 10 years? (check one)	❑ No change ❑ Increase ❑ Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford the policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one)	**Applicant** ❑ Yes ❑ No **Spouse** ❑ Yes ❑ No
If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?	❑ From my (our) Income ❑ From my (our) Savings/Investments ❑ My (our) Family will Pay
The national average cost of care in 2010 was $77,000[1], but this figure varies across the country. In ten years that national average annual cost would be about $125,425 if costs increase 5% annually.	
What elimination period are you considering? Number of Days: Approximate cost for that period of care:	**Applicant** / **Spouse** _____ / _____ $_____ / $_____
How are you planning to pay for your care during the elimination period? (check one)	❑ From my (our) Income ❑ From my (our) Savings/Investments ❑ My (our) Family will Pay

[1] National Clearinghouse for Long-Term Care, Costs of Care in the United States, 2010; www.longtermcare.gov.

LONG-TERM CARE INSURANCE PERSONAL WORKSHEET

NEW YORK LIFE INSURANCE COMPANY
51 Madison Avenue, New York, NY 10010

To be completed by the APPLICANT(s) and returned

QUESTIONS RELATED TO YOUR SAVINGS AND INVESTMENTS

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)	**Applicant** ❑ Under $20,000 ❑ $20,000-$30,000 ❑ $30,000-$50,000 ❑ Over $50,000	**Spouse** ❑ Under $20,000 ❑ $20,000-$30,000 ❑ $30,000-$50,000 ❑ Over $50,000
How do you expect your assets to change over the next 10 years? (check one)	❑ Stay about the same ❑ Increase ❑ Decrease	

If you are buying the policy to protect your assets and your assets are less than $30,000, ($60,000 for Applicant and Spouse both applying), you may wish to consider other options for financing your long-term care.

DISCLOSURE STATEMENT

❑ The answers to the questions above accurately describe my financial situation.
Or
❑ I choose not to complete this information.
(Check one)

❑ I acknowledge that the carrier and/or its agent (below) have reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. **I understand the above disclosures. I understand that the rates for this policy may increase in the future.** (This box must be checked.)

Signed **X** _____ (Applicant)	_____ (Date)
Signed **X** _____ (Spouse)	_____ (Date)

❑ I explained to the applicant the importance of completing this information.

Signed **X** _____ (Agent)	_____ (Date)
Agent's Printed Name: _____	

My agent has advised me that this policy does not seem suitable for me. However, I still want the company to consider my application.

Signed **X** _____ (Applicant)	_____ (Date)
Signed **X** _____ (Spouse)	_____ (Date)

The company may contact you to verify your answers.

NOTICE TO APPLICANT(S) REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

NEW YORK LIFE INSURANCE COMPANY
51 Madison Avenue, New York, NY 10010

To be returned with Application, if Replacement is involved

Save This Notice! It May Be Important To You In The Future

According to your application, you intend to lapse or otherwise terminate existing Accident and Sickness or Long-Term Care/Nursing Home Insurance and replace it with an individual Long-Term Care/Nursing Home and Assisted Care Living Facility Insurance policy to be issued by New York Life Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new coverage.

You should review this new coverage carefully, comparing it with all Accident and Sickness or Long-Term Care/Nursing Home Insurance you now have, and terminate your present policy only if, after due consideration, you find that purchase of this Long-Term Care/Nursing Home and Assisted Care Living Facility Insurance coverage is a wise decision.

Statement to Applicant(s) By Producer

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long-term care/nursing home insurance coverage, you may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant(s)" was received on: _____
Date

_____
Writing Producer Name (Please Print)

X _____
Signature of Writing Producer

_____
Writing Producer Address (Please Print)

X _____
Signature of Applicant

X _____
Signature of Spouse

NOTICE TO APPLICANT(S) REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

NEW YORK LIFE INSURANCE COMPANY
51 Madison Avenue, New York, NY 10010

To be retained by APPLICANT(S) if a Replacement is involved.

Save This Notice! It May Be Important To You In The Future

According to your application, you intend to lapse or otherwise terminate existing Accident and Sickness or Long-Term Care/Nursing Home Insurance and replace it with an individual Long-Term Care/Nursing Home and Assisted Care Living Facility Insurance policy to be issued by New York Life Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new coverage.

You should review this new coverage carefully, comparing it with all Accident and Sickness or Long-Term Care/Nursing Home Insurance you now have, and terminate your present policy only if, after due consideration, you find that purchase of this Long-Term Care/Nursing Home and Assisted Care Living Facility Insurance coverage is a wise decision.

Statement to Applicant(s) By Producer

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long-term care/nursing home insurance coverage, you may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant(s)" was received on: _____
Date

_____
Writing Producer Name (Please Print)

X _____
Signature of Writing Producer

_____
Writing Producer Address (Please Print)

X _____
Signature of Applicant

X _____
Signature of Spouse

LONG TERM CARE INSURANCE CONDITIONAL RECEIPT

NEW YORK LIFE INSURANCE COMPANY
51 Madison Avenue, New York, NY 10010

To be completed by the PRODUCER and Retained by the APPLICANT(S)

Conditional Receipt For Payment of Advance Premium With Application

_____	_____
Applicant Name (Please Print)	Spouse Name (Please Print)
$_____	$_____
Applicant Amount (Please Print)	Spouse Amount (Please Print)

I have received from the Applicant(s) named above, on this date, a signed Application for New York Life Insurance Company's Long-Term Care Insurance or Nursing Home and Assisted Care Living Facility Insurance Policy, and the amount(s) shown as advance payment.

If an amount is shown for the Applicant or Spouse above and if a specific Policy Effective Date is not requested by the Applicant(s), New York Life will approve or decline the Application based solely on the health status of the Applicant(s) through today's date. This may include a telephone or personal interview conducted after the Application is received by New York Life to determine the health status of the Applicant(s) on this date.

If a specific Policy Effective Date after today's date is requested by the Applicant(s) New York Life may consider the health status of the Applicant(s) up until the requested Policy Effective Date in deciding whether to approve coverage or to deliver a Policy to the Applicant(s).

If cash has been submitted with the Application and a specific Policy Effective Date after today's date is requested by the Applicant(s) and all of the answers to the Eligibility Questions on the Application are accurately answered "No," then the Applicant(s) will have temporary coverage in force from today's date until the earlier of the following:

- The Application for coverage is declined by New York Life and the cash submitted with the Application is returned to the Applicant(s); or
- 60 days have elapsed.

Benefits payable for losses incurred during the period for which temporary coverage is provided are payable according to the Policy terms and plan applied for, not to exceed $1,000.

This advance payment does not pay for interim coverage, and there is no coverage in effect unless New York Life approves the Application, except for the temporary coverage if the Applicant(s) has made a payment and not requested a Policy Effective Date later than today's date as described above.

If the Application is approved, the coverage, under the terms of the issued Policy, will begin on the date the Application was signed or a later date if a later Policy Effective Date is specifically requested by the Applicant(s) in the Application. If the answers to the Eligibility Questions on the Application are answered "No," We have relied upon the "No" answers to accept the advance payment and give the Applicant(s) this Conditional Receipt. If these answers were incomplete or incorrect, the advance premium may be returned and this Conditional Receipt will be null and void. The advance payment may also be returned and this Conditional Receipt be void if New York Life is unable to approve the Application within 75 days.

The check for the advance premium must be made payable to New York Life Insurance Company, and not made payable to the producer or left blank. The check is accepted subject to collection only.

_____	**X** _____
Date	**Signature of Writing Producer**

PRODUCER STATEMENT AND CERTIFICATION

NEW YORK LIFE INSURANCE COMPANY
51 Madison Avenue, New York, NY 10010

To be completed by Producer and returned

PRODUCER PROVIDED INFORMATION, STATEMENT AND CERTIFICATION

1. List all health insurance policies you have sold to the Applicant(s) which are still in force:

Insured	Carrier	Policy Number	Type of Policy

2. List all health insurance policies you have sold to the Applicant(s) in the past five years which are no longer in force:

Insured	Carrier	Policy Number	Type of Policy

3. If existing health or disability insurance is being replaced or changed, have you given the Applicant(s) a Notice to Applicant(s) Regarding Replacement of Individual Accident and Sickness or Long-Term Care Insurance?
   ❑ Yes ❑ No
4. In what type of dwelling does (do) the Applicant(s) currently reside?

❑ Private Home ❑ Apartment ❑ Retirement Home
❑ Nursing Home ❑ Mobile Home ❑ Adult Care Home
❑ Assisted Living Unit ❑ Personal Care Home ❑ Adult Foster Home
❑ Retirement Community ❑ Continuing Care/Life Care Community
❑ Congregate Care Community ❑ Other Please Specify: _____

Producer's Statement and Certification

I certify that the Applicant(s) has read or had read to him/her the completed Application including all the answers that are recorded in the Application for Long-Term Care/Nursing Home and Assisted Care Living Facility Insurance and to the best of my knowledge and belief the answers recorded in the Application are complete and true. The Applicant(s) understands that New York Life Insurance Company will rely upon the answers in the Application. If the answers are not true and complete the policy may not be valid and an otherwise valid claim may be denied. The Applicant(s) realizes that any false statement or misrepresentation in this Application may result in loss of coverage under the Policy.

If I collected cash with this Application, it is indicated in the Payment Mode section of the Application and I have given the Applicant(s) a Conditional Receipt for the cash. I have informed the Applicant(s) that no coverage is in effect until and unless New York Life approves this Application and the premiums are paid.

I have explained to the Applicant(s) that a personal interview may be conducted in conjunction with the underwriting of the Application. I also explained that medical records would be obtained from any physician listed in this Application as part of the underwriting process. I have explained the benefits of the policy which he/she has applied for in the Application.

I further understand, that if there is any reason to suspect that this insurance herein may replace any other accident and sickness or long-term care insurance, I must sign both copies of the "Notice to Applicant(s) Regarding Replacement of Individual Accident and Sickness or Long-Term Care Insurance" (Notice). I will explain its contents to my client(s) who will also sign both copies of the Notice and keep one copy. I will return the other signed copy with my client(s) Application.

I witnessed the Applicant(s) signature to this Application. ❑ Yes ❑ No

I have also evaluated the suitability of the purchase of this coverage for my client(s) and have either obtained a completed Long-Term Care Insurance Personal Worksheet or have advised the client(s) that if no financial information is disclosed, or if the coverage does not appear to be suitable, then New York Life will send them a Suitability Letter. The client(s) then can instruct underwriting to continue without regard to the product's suitability. My client(s) understand that the underwriting of their case would continue at that time.

_____ _____
Writing Producer's Name (Please Print) Writing Producer's License No.

_____ **X** _____
Date **Signature of Writing Producer**

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PRODUCER REPORT

NEW YORK LIFE INSURANCE COMPANY
51 Madison Avenue, New York, NY 10010

PRODUCER completes and returns

APPLICANT(S)/SALE INFORMATION

Name of Applicant:	**Name of Spouse:**

Did you personally interview the Applicant(s)? ❑ Yes ❑ No

What is your evaluation of the Applicant(s)?

a. Surroundings? (Condition of residence, living arrangement) ❑ Did not visit home

b. Mental capabilities and alertness?

c. Please provide any information pertinent to the underwriting process not already disclosed.

Within the last 6 months have you written a New York Life (NYL) case on either Applicant which required medical records?
❑ Yes (indicate policy #) _____ ❑ No

For AARP A2O Agents, did this sale result from use of the AARP co-brand? ❑ Yes ❑ No
If "Yes", include proposed insured's AARP membership number _____

	Applicant	**Spouse**
Risk Class Quoted (Check appropriate box)	❑ Preferred ❑ Standard ❑ Class 3 ❑ Class 4	❑ Preferred ❑ Standard ❑ Class 3 ❑ Class 4
Premium Quoted/Mode	$_____Mode_____	$_____Mode_____
Premium Discount Quoted	❑ Marital ❑ Sibling ❑ Multi-Life	

Did you give the Applicant(s) a Conditional Receipt? ❑ Yes ❑ No

PRODUCER INFORMATION

If more than 3 producers are involved in the sale use an additional Producer Report.

Note: All producers involved in the sale are required to be licensed, appointed and complete all applicable Long-Term Care Insurance state required training in both the state of solicitation (signature state) and the applicant(s) state of residence.

Writing Producer

Full Name: First	Middle	Last	Producer Code:
Telephone Number ( ) –	Email Address:		Commission Split (%):

Please select one of the following responses:

❑ I am a TAS Agent: ❑ I am **NOT** a TAS Agent:

If you are a TAS Agent, please note if any of the relationships below are applicable for either the applicant or the spouse. ("Family member" includes parents, spouse, siblings or children related by blood, marriage, or law AND a Family member of another NYL agent.):

❑ Self ❑ Family member ❑ Other NYL agent ❑ Other *(not self, Family member or other agent)*

SIGN Producer Return

PRODUCER REPORT

NEW YORK LIFE INSURANCE COMPANY
51 Madison Avenue, New York, NY 10010

PRODUCER completes and returns

Writing Producer 2

Full Name: First	Middle	Last	Producer Code:
Telephone Number ( ) –	Email Address:		Commission Split (%):

Please select one of the following responses:

❑ I am a TAS Agent ❑ I am **NOT** a TAS Agent

If you are a TAS Agent, please note if any of the relationships below are applicable for either the applicant or the spouse. ("Family member" includes parents, spouse, siblings or children related by blood, marriage, or law AND a Family member of another NYL agent.):

❑ Self ❑ Family member ❑ Other NYL agent ❑ Other *(not self, Family member or other agent)*

Writing Producer 3

Full Name: First	Middle	Last	Producer Code:
Telephone Number ( ) –	Email Address:		Commission Split (%):

Please select one of the following responses:

❑ I am a TAS Agent ❑ I am **NOT** a TAS Agent

If you are a TAS Agent, please note if any of the relationships below are applicable for either the applicant or the spouse. ("Family member" includes parents, spouse, siblings or children related by blood, marriage, or law AND a Family member of another NYL agent.):

❑ Self ❑ Family member ❑ Other NYL agent ❑ Other *(not self, Family member or other agent)*

If more than one producer is involved in the sale, who is to receive correspondence related to the application and policy? *(Select only one producer)*

❑ Writing Producer ❑ Producer 2 ❑ Producer 3

❑ Other (Please specify)_____

_____ **X** _____
Date **Signature of Writing Producer**

SIGN Producer Return

NOTES

NEW YORK LIFE INSURANCE COMPANY
51 Madison Avenue, New York, NY 10010

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Long-Term Care Insurance

New York Life Insurance Company
51 Madison Avenue
New York, NY 10010

For more information, please call
1-800-224-4582

visit our web site at
www.newyorklife.com

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